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NATIONAL HEALTH CONGRESS

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An answer to government control—a challenge to the health professions

REAMS of paper have been consumed in developing the theme that the health of all the people is one of the pressing problems facing the nation. At no time in the history of hospitalization and medicine has the subject of national health care come in for so much public attention. More and more people, both public and private figures, have injected themselves into the situation, exhibiting great concern.

As a matter of fact, to the lay reader without specific knowledge of the actual condition of public health in this country, it would appear that we as a nation are in dire straits; that the health of this country is in such a precarious position that physical bankruptcy will be the near aftermath unless remedial measures are immediately taken.

We Are Really Quite Healthy

This is not the case. We are a remarkably healthy people. No nation has ever equaled our current standard of health. No nation has ever possessed the facilities and professional abilities such as we possess to safeguard that standard. No nation has ever been able so confidently to anticipate an even higher standard through the normal process of year-by-year improvement. Unfortunately, this very bright light has been too well hidden under a very dark bushel.

The accomplishments of those concerned with safeguarding the physical well-being of the American public have received far too little attention. Headlines about the extension of the Social Security Act to cover the health needs of all people regularly make the front pages of our big daily newspapers, but the increase of nearly fifteen years in the average life span through disease control and improved surgery, being a statistical fact, usually appears in smaller type on the financial pages of the same newspapers or as a dull article in our higher level magazines.

The scientific improvements in public health contributed by private sources, the steady and encouraging extension of voluntary prepaid protection, as exemplified by the increase in Blue Cross membership, are constantly being pushed out of the spotlight by the proclamations of those who would force John Q. Public to be full of health whether he is interested in being healthier or not.

More surveys have been made in this country in the last ten years on the condition of public health by both government and private sources than in any other period in the history of this country. The conclusion arrived at by all of these probing diagnoses is that *there is a public health problem*. Unfortunately, that is about the net contribution of most surveys on the subject.

There is too little definition of the basic nature and extent of the problem; too little knowledge of the exact condition of the public health by economic and geographic breakdowns; too little certitude about the actual attitudes and interests of all the people to the whole problem of health—either of their own or of their fellow citizens'.

Finally, public health diagnosticians, lacking adequate definition of all the dimensions of the problem, fail to come up with a comprehensive and logical answer on how the health of this nation can ultimately be best extended and thereby raised to an even higher level than we now enjoy.

We would fail miserably to be realistic if we were to shrug off this growing hue and cry as "much ado about nothing." It would be fatal for both the hospital and the medical professions to feel that the demand for a method of bringing health to all people is in any sense ephemeral. Public health protection, at all levels, we are going to have—one way or another.

Some proof of the trend is presented by the activities in our state legislatures. The introduction of bills providing for compulsory health care is becoming almost commonplace. In 1945 there were more than 30 bills of this character introduced in 12 states.

Health Legislation a "Must"

More pointed still is the federal attitude. One of the 15 pieces of "must" legislation which President Truman has asked for and Senate Majority Leader Barkley has listed as being early on the calendar for this newest session of Congress is the extension of the Social Security Act to encompass a health plan for all the people. A brand new bill or another variation of the Murray-Wagner-Dingell Bill may actually have been introduced before you begin reading this article.

The increased socialistic tempo that came to Great Britain with the success of the Labor Party in its last election will also have bearing on the global trend toward extended

public benefits through government action. According to news services this is already bearing fruit in South America. Its ripples will also touch the shores of the United States and will help to firm the stand of our social security crusaders.

Complete health protection for every individual in this country is eminently desirable. As an objective, it is consistent with American thinking, the American habit of reaching for the ultimate. Our people want this protection. Certain strongly united segments of the public are demanding it in a loud and persistent voice. And it is not impossible to give it to them, provided the methods employed to achieve it are right.

However, the only plan nearing the action stage is health by federal fiat. The public has no understanding of the initial negative implications or the long-range negative consequences of the Murray-Wagner-Dingell Bill, and there is no voluntary national health plan being offered to it.

What can professional people in the health field do about it? What *will* they do about it? Certainly, it is obvious that if the voluntary forces in this country do nothing about it they will lose, and the country will also lose, by default.

This article need not concern itself with the advantages to the people of health through voluntary means. Hospital administrators are in the best position to know that the nation's health, through the voluntary professions properly extended, is in far safer hands than it could possibly be if the same abilities were regimented or dominated by the government. This article is written simply to outline a method or plan that will ensure that the nation's health *shall remain in free hands;* that it shall be protected and promoted in a free atmosphere which will ensure the continuance of the advances made in health care by private initiative.

A cold analysis of the whole situation leads inevitably to the conclusion that no one group of people concerned with any one of the various segments of health can possibly evolve a satisfactory answer to the demands that are now before us. There is no one existent group of individuals, however well knit or well organized in its own activities, that can possibly encompass all of the things that are being promised the public under the Murray-Wagner-Dingell Bill. For this reason it is equally obvious that if private sources are to deliver to the American public a health package as promising as that proposed by government, it can be done only by the complete merger of all of these private sources. To this end and for this reason we propose the *National Health Congress.*

WHAT IS IT?

At the present time the National Health Congress is an idea, a new idea conceived as the only logical and possible plan through which the existent private health forces can hope to compete with the offer of complete health coverage by the federal government.

FORMATION AND OBJECTIVES

The National Health Congress would be formed by merging or pooling all voluntary health abilities to accomplish these objectives:

1. Extending a standard health protection to all people through voluntary means.
2. Extending the physical facilities for health to the point where complete protection becomes possible for all people of whatever status and wherever located.
3. The national coordination of all health agencies and their activities to this end.
4. Effecting a plan of voluntary prepayment of health protection at an equal or lower cost than that proposed by the Murray-Wagner-Dingell Bill.
5. Education of the public on all matters pertaining to health, tending both to improve national health standards generally and to increase public interest in taking advantage of the facilities for health improvement.
6. The continuation of incentives for those in all phases of health care.

TYPE OF ORGANIZATION

The National Health Congress is envisioned as a national organization patterned after our national legislative congress. As proposed, it would be not merely an organization providing a public forum for the discussion of health practices and objectives, but a legislative body created by the voluntary health forces and endowed with the power to act for them.

These Replies Indicate the Reactions of Business

President of a Major Railroad:

A National Health Congress could be made to serve an excellent purpose from the standpoints of educating both the lay public and the medical profession with regard to the economic problems of modern medical care and the possible means of solving these problems. The participants in such a congress should be representatives of the medical profession; professional political scientists, economists and sociologists; representatives of industry, commerce and transportation; representatives of the labor groups; representatives of the agricultural groups; and representatives of foundations, such as the Rockefeller Foundation, the Kellogg Foundation, the Milbank Memorial Fund, the Commonwealth Fund and the Farm Foundation, and such other agencies as have a vital public interest in the solution of the problem of adequate medical care for all of the people of the nation.

A National Health Congress, broadly representative, would, of course, devote itself entirely to the discussion of and the search for a solution of the problems involved in the cooperation of the medical profession and the people it serves in developing a plan whereby all the people may benefit from modern health services. It would doubtless be recognized at once that the science and the practice of medicine are matters that should be left in the free hands of professional people, but, of course, it would not be maintained that the economics of medical care should be left entirely in the hands of the medical profession. That is a matter of mutual interest. . . .

If your appeal to a business man for assistance is based upon interest in the general welfare, you will get a hearty response. If it should seem to be based upon the desire of the medical profession to have complete control in its own interest of the economics of medical care, I believe that the best business men of the country would not respond favorably. . . .

I greatly hope that the medical profession will see the importance of organizing a National Health Congress, broadly representative, in which the whole purpose will be to face squarely and endeavor to solve the problem of providing modern health services for all the people. . . . Sincere, fervent and intelligent action for the solution of the economic problems of medical care is the one effective method of retaining a maximum of private enterprise in the practice of medicine.

President of a Leading Furniture Manufacturing Company:

Frankly, I agree with you that the first and most crying need of the profession is one over-all organization, such as the National Health Congress. Only through such an organization can your work be made really effective.

Publisher of a Metropolitan Newspaper:

Of course, we agree that government control of medicine would be inimical to the cause of all free enterprise and its continuance but, even beyond this, we fear that government control of medicine, regimentation of our doctors and hospitals would lead to nothing but chaos.

We agree completely with the premise that the best, if not the only, way to prevent government control of medicine and further jeopardy of the free enterprise system is by organization and unified intelligent action of all those involved.

General Manager of an Agricultural Association:

We believe the health congress proposal outlined in your pamphlet would be a good thing. I would endorse such a plan and it is my opinion that industry as a whole should be interested.

President of a Leading Business Machine Company:

The present groups representing medicine and those representing the hospitals so far either have failed to recognize the possibility of the socialization of medicine or, in recognizing, have been so reactionary in their thinking that they refuse to come forward with anything constructive by which it can be combated.

As you say, it is essential to perform this function of caring for the general public's health by the free enterprise system and if your committee, the National Health Congress, will attack the matter constructively but with sufficient liberal thinking so as not simply to "bat their heads against concrete walls," I would thoroughly endorse the effort. One state cannot do it alone. You will need the support of a vast majority of the doctors and hospitals in the United States to make it effective.

General Manager of a Large Broadcasting Company:

I believe that the suggestion of a National Health Congress would represent sound counter strategy because it would give your profession a positive program to offer against the Social Security "Do Good-ers" who are becoming increasingly vocal in their efforts to regiment the field.

President of a Leading Medical and Surgical Products Company:

It is difficult to appraise the practicability of the National Health Congress proposal. One thing, however, is clear, and that is that there is real need for the extension of adequate medical service to many people now denied such benefits. I am glad to see the indication that the profession is interested in providing such health protection on a voluntary basis. Clearly, unless a practical plan is developed and effectively presented, we must anticipate government intervention.

President of an Important National Bank:

I have reviewed your proposal with much interest and subscribe to the conclusions expressed; I believe that, in the main, the public generally would be receptive to the creation of an organization as proposed.

MEMBERSHIP

As proposed, the National Health Congress membership would be made up of a representative or representatives of (1) each state hospital association, (2) each state medical association, (3) each state dental association, (4) each state nursing association, (5) each state pharmaceutical assocation, (6) the industry of each state, (7) the labor of each state, (8) the agriculture of each state and (9) a representative of the United States Senate, the House of Representatives and the United States Public Health Service.

SCOPE OF THE CONGRESS

The scope of the National Health Congress would cover all measures affecting health care on the national plane, specifically those aimed at:

1. Extending standard health coverage to all people of any economic status wherever located.
2. Extending facilities and research projects necessary to further the improvement of health standards of the nation.
3. Evolving a sensible prepayment method, covering all items of health care on an economical cost basis for the individual or family unit.
4. Studying and recommending to the federal and all state governments their proper and most productive participation in the health activities of the nation and the states, particularly the endowment of greater research projects, and the extension of benefits to the indigent and public wards.
5. Empowering a national health administration under its control to carry out its directives.

INITIAL WORK PROCEDURE

The National Health Congress should be established in permanent quarters in the city most accessible to its members and best adapted to the work of carrying on its administrative functions.

The congress should convene at least once a year to decide measures affecting extension of national health and improvement of standards, just as our national legislative Congress meets to consider the whole welfare of the nation. Since its field would be restricted to health, the time required from members would not interfere too much with their private affairs. With the proper machinery provided for a national body of representatives empowered to act, a great amount of work could be accomplished in a short period of time.

The work of the congress would be expedited by placing specific health divisions or projects in the hands of committees for study and recommendations before the full congress is asked to vote on them. In other words, the better and more workable procedure methods used by our national legislative Congress would be borrowed to form the pattern of procedure for the National Health Congress.

This program is offered as a preliminary and necessarily rough draft of how the voluntary health forces could equip themselves effectively to forestall government control and regulation of health care.

Through this kind of completely coordinated organization, and only through this kind of united effort, can private forces hope to accomplish what the government proposes through the Murray-Wagner-Dingell Bill.

There may be some who will contend that this proposal is too big, that it would be impossible to accomplish. To these individuals we should like to make just two observations.

The first of these is that all projects that have brought great benefit to great numbers of people have been thought of by a portion of those concerned as impossible of accomplishment. Medicine and surgery alone offer numerous examples.

The second observation is that there is no other alternative within the time remaining for action by nongovernmental forces. If, however, the American people were shown some disposition on the part of the health professions to *offer* a program that promised a better solution under private control, the public might have some reason to wait—the government would have less reason to label health extension "must" legislation and to push it vigorously.

There may be those who will question the advisability of giving membership in the congress to industry, to labor and to agriculture. Broadly speaking, these three groups are the public of the professional people. It's not only your health but their health which is under consideration. They have a right to be heard and to have a hand in shaping the perfect national health plan. If the health professions fail to give it to them, labor, at least, will feel that it can get it from the government.

There are other practical reasons for their inclusion. The voluntary health forces need the cooperation, the organizational abilities and perhaps the financial help of industry to put over any national health plan under private control. They also need the belief of labor in their sincerity or labor will turn to government. No better proof of complete sincerity and unselfishness could be offered by the health professions than an invitation to industry, agriculture and labor to participate in building the best health plan for the whole nation.

There is plenty of evidence that the formation of the National Health Congress by the voluntary forces will meet with enthusiastic lay interest. To ascertain if this might be counted on, the Michigan Medical Society wrote directly to the presidents of a large number of industrial concerns, banks and newspapers. The excerpts (see page 45) from replies adequately indicate the reaction of business.

EXPRESSIONS ARE TYPICAL

These expressions of interest are typical of the replies received. In addition to this manifestation of industry's approval, the Michigan Medical Society to date has discussed the preliminary proposal with the presidents of 25 state medical societies. In each case the response was on the favorable side.

While this idea of a National Health Congress is still in swaddling clothes, it needs only the interest, care and guidance of the professions to grow quickly into a lusty youngster with a sparkling future. It may not be the only way to obviate government control of health but it can be the most direct and comprehensive answer to the problem facing the professional health forces of the country.

Even assuming the threat of government control were eliminated, a National Health Congress created and controlled by private enterprise is a challenge worthy of the talents that have built this nation into the healthiest on the globe.

Is the challenge too big for the health professions? We believe not, but only the health professions can supply the answer.

When They Come Marching Home

A plan for the reemployment of veterans

LOIS D. McCOY
Personnel Director
Massachusetts General Hospital
Boston

A WELL-ROUNDED plan for the reemployment of veterans has been included in the personnel program of most hospitals. Such a plan has been recognized as a vital part of our current employe relations. With the increase in the numbers of returning veterans, the importance of this plan of assimilation and adjustment becomes increasingly evident.

What is the plan? How is it working? In the light of experience at this point, shall we revise it?

Inventory. Many hospitals know the number of men who expect to return to work when they are released from the armed services. They know from having sent questionnaires to the men themselves whether the returned veteran expects to take up the old job or whether he hopes for other openings because of added skills or changed health status. They can plan, therefore, what to do with the present staff of workers and can evaluate the training program.

The Plan. The program for veterans includes the hospital policies for receiving and placing (1) veterans who are former employes and (2) veterans who have never before been employed in the hospital.

Already experience has shown that the veteran needs and should have special handling in his employment and induction procedures. The interview procedure, induction and follow-up, training, refresher training and supervision must all recognize his special problems.

The Interview. The person selected to interview returning veterans should be thoroughly informed on all rights and problems of veterans and should have a flair for dealing with people. Most large cities have offered lectures by men and women prepared to advise on these points. These have been widely attended by personnel and supervisory people.

Through these sources and through firsthand experience, we now know that the veteran is not the man he was when he went away. He may be better, he may be worse —but he is different. Most of these men are young. They were reared in the philosophy of the Golden Rule. They were taken abruptly out of their earlier environments and were taught technics of self-preservation and combat. It was a hard intensive training. They have lived and practiced these technics for two or three, sometimes four, years.

When they return they bring with them mental habits of suspicion, action habits of disciplined obedience to direction. Suspicion has been self-protective. They have seen lack of suspicion kill their "chums." Obedience to a petty officer or top sergeant is automatic.

They want to throw these things off. More than anything they want to become citizens of the United States with the Four Freedoms a matter of course. They know it will take time. Do we realize it?

To begin with, in the initial interview, we must remember that the selection of a job is one of the first steps the veteran is taking without orders from someone higher up. Second, we must recognize that for months or years he has been hearing stories of big wages for civilians at home. Overseas nothing less than a hundred dollars a week was talked of. He has been trained and experienced in suspicion and he suspects that we are putting something over on him when we offer him our hospital rates of pay. Third, if he was in the ranks, he has been accustomed to a most limited vocabulary for his period overseas.

So, give this man all the time he wants. He has to make up his mind. The top sergeant would say, "You can do this job. Take it." But the hospital staff must live with the man if he is taken on and the time of a supervisor cannot be given to train him if he won't stay. The hospital pay rates should be explained. Show that they range with hotels and restaurants and are as good as or better than those of other hospitals in the area. Conversation should be kept at a level of simple words and phrases, with an atmosphere of quiet interest. There should be no urging or coercion.

It is unsafe to lay down general rules. Certain tendencies can be noted. Every man reacts differently in some degree and what works well with one man may not with another. The ultimate plan decided upon must be the one that is made and

accepted by the man himself. If he is encouraged to look at a job from all sides, to consider the security of the hospital job, medical care, vacation and sick leave with pay, wages in the middle range of the community pay rates instead of high pay in industries, he can make his own decision.

Welcome by Administration. After the interview the veteran who has previously been a member of the hospital family should be welcomed by the director or one of the assistant directors. A word of greeting and a handclasp will do much toward establishing a good relationship. This recognition of their co-worker has a bearing on the morale of the whole.

In Training. The in-training program helps the veteran. If the personnel program includes an orientation period of one or two talks and a tour of the hospital, the veteran takes another step in becoming an integral part of his new environment. If he can think of the hospital as a service agency and himself as a part of it, it will help his morale.

Supervision. Training, refresher training and supervision are squarely up to the supervisors, whether they are head nurses, dietitians or others. Even under the pressure of the scanty war labor market, this group has been remarkably patient and perceptive with the returned veteran. Many have attended lecures on their own time to become more familiar with the problems involved.

Medical Aspects. Many hospitals have preemployment medical examinations or examinations within a week or two after work starts with a proviso that the employment is not confirmed until the doctor's report comes in. We know that the reports of the physical and mental examinations in the armed services are not usually available. We are dependent on our own resources and the measure of detailed examination that our doctors deem sufficient. Even so we are better off than most industries.

The results of medical and psychological examinations involve many factors, including safety, and may have far-reaching effects. What jobs can a handicapped veteran do? How severe is his disability? Are his courage and ambition greater than his ability? We must know all of these things.

The Handicapped. Some hospitals have already analyzed every job in the hospital to determine what can be done with workers having hand, arm, leg, heart, back and other handicaps. These jobs were surveyed for war period workers. Such a survey should be continued if we have handicapped veterans to consider. For the hospital already geared to the use of handicapped workers the challenge of the handicapped veteran is not too great. Experience shows that a handicapped man or woman placed in a job geared to the ability of the worker gives consistently good performance, with satisfaction to the hospital and the worker.

At this time hospitals have had two types of returned veterans with handicaps: one, the physical, the other, the psychological. There is little difficulty with the veteran with only a physical handicap if he is placed in a job equal to his ability. He may prove to have greater capacity than we expected.

A returned operating room orderly is a case in point. There is a background of a happy married life, a good work history, a stable personality and a good Army record.

One day he walked into the personnel office saying, "Well, here I am." He had a confident, direct gaze as he stood at attention. There was no hand showing at the cuff of his left sleeve.

What to do? After talking a little he said, in answer to a question, "I'll go wherever you send me and do the best I can."

This man knows orderly work, knows orderlies. Surely, there ought to be something he could do in that service. His old supervisor agreed to take him back. With a hand and wrist gone this man is back doing work in the operating room. He does every single thing he ever did, including putting patients into position. As soon as his arm is ready he will have an artificial hand.

Needless to say the doctors and nurses like him. "How did you lose your mit?" a doctor asked him one day, "Oh, I swatted Hitler with it," he answered with a grin.

The neuropsychiatric discharges are more difficult. A knowledge of the original background of the man helps in understanding what we may hope for as an outcome in employment. Some have a good stable history of school and work; some have been drifters, never settling down to any project for long. The psychological casualty may also have a diagnosis of "combat fatigue." This diagnosis may be made after a short or a long period in the armed services or it may come after an honorable discharge and a rest period at home. It means that most men have a breaking point somewhere along the line and these men have reached that point.

Hospitals are fortunate in that they have psychologists and psychiatrists available when advice is needed by men in this group or by the supervisors who are handling them. For these men placements where there are many or sudden noises should be avoided. Men with mild forms of this malady can hold jobs and are found in hospitals and in industry. They tend to be restless and have difficulty sticking to a job.

Such men are likely to hate routine. They may also be restive under the constant change of a floor orderly job because there are too many orders from too many people. They are kept too active for too long periods. They may do better at an ambulance job or truck job, going from place to place. Many of these returned veterans need the special treatment that only a psychiatrist can give.

Treat Him as a Normal Man

In dealing with the handicapped veteran, we should treat him as we treat the normal man. We have all been told about, and have followed, the technic of showing no curiosity about the veteran's experiences unless he shows an inclination to discuss them. Our aim is to help the veteran back into useful employment and to see him accepted as a co-worker by the total employe group.

We have the program for the returned veteran. Each day sees it tested. Adjustments and changes may be indicated. Sensitive watching of the plan must be the job of some one person on the personnel staff.

Counseling the veteran is an important civic duty, as well as a privilege. What happens to these men, individually and collectively, may determine the future trends of the United States. The attitudes of these veterans toward labor, industry, our traditional form of government and its application are of concern to employers everywhere. Their reentry into civilian life must have honest consideration.

ADMINISTRATION

A.C.H.A. survey shows the need for educational opportunities

DEAN CONLEY
Executive Secretary
American College of Hospital Administrators

A SIGNIFICANT group of men and women in military service is interested in the possibilities of hospital administration as a career. These men and women have been engaged in assignments similar to certain aspects of civilian hospital administration and believe there may be a future in this field for them. A comparatively small number has had hospital experience prior to entering the armed forces, and only a few of these were engaged in hospital administration.

A number of factors will affect their choice of vocation and ultimate placement upon release from service. There is reason to believe, however, that from this group will come many persons who will eventually find employment in civilian hospitals.

Stress Need for Training

An immediate parallel to this interest in hospital administration as a means of livelihood is the increasing emphasis on specialized training for the particular vocation. University courses in hospital administration are now available and there are splendid prospects of other courses being added in the near future. The success of these courses to a marked degree depends and will continue to depend upon the quality of enrollment. Eligible war veterans with administrative experience stand to benefit greatly from training through such programs. Assistance is available under the G.I. Bill of Rights. Universities are interested in knowing the past experience and educational background of these prospective students.

Two distinct groups of military personnel contain potentialities for civilian hospital administration. The individuals in these groups were queried through surveys conducted by the American Medical Association and the American College of Hospital Administrators. The committee on postwar medical service of the American Medical Association sought, among other things, to discover how much interest medical officers have in training for hospital administration.[1] The American College of Hospital Administrators prepared its questionnaire to determine the interest of Medical Administrative Corps officers "in additional educational opportunities to prepare them better for careers in civil hospital administration."

The American Medical Association study of more than 21,000 questionnaires returned from physicians in the Army, Navy, Public Health Service and Veterans Administration revealed only 45 who expressed a desire for training in hospital administration. In appraising this fact it should be borne in mind that a relatively small percentage of physicians replying were engaged in administrative assignments. Six medical officers indicated an interest in sufficient training "to make them recognized specialists in hospital administration."

The A.C.H.A. questionnaire was mailed to approximately 10,000 Medical Administrative Corps officers in nearly every theater of operation. A total of 2452 questionnaires was returned of which 1397 stated an interest in additional training in hospital administration on release from service; of these 460 are eligible for the established university courses. Each Medical Administrative Corps officer reporting gave information as to present rank, age, interest in training, previous hospital experience, other experience and complete data on education. The following salient points were brought out.

Universities and Colleges:
144 colleges and universities are represented by the 460 officers.

Age Groups:
All are between 21 and 60.
Under 25: 62
Ages 26 to 30: 239
Ages 31 to 40: 142
Ages 40 to 60: 17

Interest in Additional Training:
396 stated without qualification that they were interested in further training for civilian hospital administration.

24 requested information on job placement following such training, income possibilities of civilian hospital administration, scholarships and details on course of study.

Previous Hospital Experience:
29 reported hospital and administrative staff experience.

3 (physicians) had medical staff appointments.

13 reported experience in other civilian health agencies.

30 reported semiprofessional assignments, such as laboratory technicians. Classified in this group were 12 pharmacists.

Other Experience:
97 reported administrative or executive experience in other fields. Under this classification was included only experience in positions, such as managers, department heads, directors, school principals, presidents and superintendents, where the reference suggested a substantial executive function. Assignments such as office managers, credit managers, purchasing agents or supervisors were noted only if the officer indicated special-

[1] Lueth, H. C.: Postgraduate Wishes of Medical Officers: Final Report on 21,029 Questionnaires, J. A. M. A. **127**:759 (March 31, 1945).

ized education in business administration.

96 reported professional or technical experience. All positions which apparently required preparatory training through established courses were carried in this classification, for example, pharmacists, engineers, musicians, stenographers and draftsmen.

At the present time there are three courses in hospital administration that require a college degree on admission. These are offered by the University of Chicago, Northwestern University and Columbia University.

The program in hospital administration at the University of Chicago is entering its eleventh year. It is offered through the School of Business Administration with basic courses presented by several divisions of the university. The program is of approximately two years' duration, one academic year in residence and the second year in an administrative internship. On completion of the course candidates may qualify for a master's degree in business administration. Dr. Arthur C. Bachmeyer is director of the course.

Northwestern University, Chicago, offers a course through the School of Commerce. Approximately two years is required to qualify for the degree of master of hospital administration. An administrative internship is required of candidates who have not had substantial experience in hospital administration. The sequence of subjects on hospital administration is offered during the evening. This distinctive feature makes possible the attendance of employed persons. Dr. Malcolm T. MacEachern directs this course.

Columbia University, New York City, inaugurated a course of instruction in hospital administration on September 27. This course will be twenty-one months in duration, including thirty-two weeks in residence and a calendar year in a supervised administrative assistantship. The course will be conducted by the School of Public Health and will lead to the master of science degree. Dr. Claude W. Munger will be in charge.

There is a course (one academic year) in hospital administration for nurses offered by the school of nursing of the University of Toronto that has been operating since 1941. University academic requirements have not been insisted upon in all cases but reasonable maturity and at least four years' experience, with two of these in junior executive hospital positions, are required. The student is in residence for six months and the remaining two or three months are given to practice in hospital administration in hospitals of Ontario. N. D. Fidler is supervisor of the course in hospital administration.

St. Louis University School of Medicine for several years has offered a course in hospital administration under the direction of Rev. Alphonse M. Schwitalla, president of the Catholic Hospital Association. There is a sequence of courses that can be taken at the undergraduate level and a special sequence of courses leading to a master's degree.

The three university courses in the United States to which the 460 M.A.C. officers would probably look for additional training might reasonably be expected to graduate each year about 70 persons at the maximum. At that rate it would take nearly seven years for all of these people to receive training if they were all found acceptable.

Obviously, many of them must receive whatever training they obtain in courses to be offered by other universities, in apprentice training or in some other form.

Every encouragement should be given to eligible war veterans to take advantage of university training for hospital administration. This is an important channel through which additional well-trained persons will enter the field.

Housekeeping *Calls for Skill*

ALTA M. LA BELLE
Housekeeping Director, Michael Reese Hospital, Chicago

THE housekeeping field is wide open for skilled workers in both the art crafts and the mechanical craft fields.

These include upholstering, window shade making, and repairing portable equipment, such as wheel chairs, stretcher carts, food carts and a myriad of other such types of equipment. Rug shampooing, too, is a not too difficult job but a highly important one.

The furniture repair and refinishing shops have been crying for men of suitable aptitudes to understudy the furniture craftsmen skilled in color. It is common knowledge that this is almost a lost art.

For the female veterans there are possibilities in the linen or sewing rooms. Too, with such training as the Army has given them they should make good inspectresses after brief instruction.

Those with gardening skill, too, are hard to find in metropolitan areas.

In the laboratories there are many service and cleaning jobs which could well be performed by veterans, such as animal care and equipment cleaning.

Veterans with such skills as I have enumerated should be able to be placed without any difficulty. We who have given service the past few years with the most unskilled type of labor would welcome any replacement of these unskilled workmen with workmen who have these special aptitudes or who have had such artcraft or mechanical craft training as would fit our needs.

It would seem to me that men who are minus an eye, hand or leg could be developed by government rehabilitation into reasonably skilled workmen. It would, of course, depend on the extent of their handicap. The essential point which we must observe in hospital service is to allay the fears and apprehensions of our patients so, of necessity, these obviously handicapped workers would have to be kept pretty much behind the scenes.

Our first debt is, of course, to place our own returned veterans. Certainly, if we still have unfilled jobs first consideration would be given to returned veterans who could be trained into our service jobs and we would be willing to lend every effort to fit their skills to our needs.

MEDICINE

plans for internship, residency and postgraduate education

JEAN A. CURRAN, M.D.
President, Long Island College of Medicine, Brooklyn, N. Y.

IN THE stupendous transition from war to peace, our attempts to formulate postgraduate plans must take into account a world full of uncertainties and unpredictable changes. Although one third of most medical school and hospital staffs are still in military service, educational planning must proceed now.

Various organizations worked energetically to prepare for the postwar period. The joint committee on postwar medical service of the American Medical Association carried on extensive questionnaire studies to learn the preferences of medical veterans in advance of their discharge. These were published in the *Journal of the American Medical Association* (Aug. 19, 1944, May 12 and Aug. 4, 1945). Hospitals have been urged to expand residency and short course possibilities to the limit, and the response has been patriotic and generous, as reported in the *Journal* for July 7. The annual meeting of the Association of American Medical Colleges in October 1944 was devoted largely to the entire problem.

Kellogg Provides Funds

The Kellogg Foundation's educational program for veterans (*J.A.M.A.*, July 14) provides funds to assist a limited number of medical schools in the United States and Canada to develop comprehensive graduate and postgraduate programs. Successful culmination of this planning will depend upon the availability of teaching manpower and the release of medical veterans wishing to participate in the instruction.

Meanwhile, the medical colleges and associated hospitals must take stock of their war sacrifices and formulate reparative measures. There is general agreement that the abbreviated premedical course, the three year accelerated medical curriculum and the 9-9-9 house staff scheme, instituted to provide 10,000 additional graduates during the war, have resulted in an inevitable lowering of educational standards. As soon as possible, it is to be hoped that prewar premedical, medical, internship and residency programs may be restored.

Meanwhile, what is to be done for the 12,000 recent graduates now with the armed forces who had only from nine to twelve months of internship? Most of them will seek further internships and residencies and thereby become a valuable resource to remedy house staff shortages.

In the official announcement by the Army Surgeon General on September 13 it was estimated that the strength of the Medical Corps would be reduced by 30,000 by July 1946, with 13,000 out of uniform by the end of this year. While peace has accelerated this process somewhat, large numbers of casualties are still awaiting transportation home and treatment in American military hospitals.

During the first half of this year, these hospitals had an increase from 133,000 to 240,000 wounded men transferred from battle fields to the United States. Detailed experience tables for World War I indicate that the average overseas casualty returned to this country for definite treatment requires five or six months of further hospitalization. Hence, there was a sufficient "backlog" of cases prior to V-E Day to keep the military general and convalescent hospitals in the United States operating at or near peak load until late autumn.

Therefore we cannot expect large-scale release of medical officers until after the first of the year. It has not yet been announced when high priority medical school and teaching hospital staffs will be released to reenforce overworked faculties at home.

An analysis of 21,029 questionnaires from physicians in service reveals that approximately two thirds had been in practice and one third came directly from internships or residencies. In view of the pessimistic prediction frequently heard concerning the disappearance of the general practitioner, it is of interest to note that 27 per cent of the medical officers came from a general practice background, and the great majority of them indicated an intention to return to it. Among the 60 per cent that expressed a desire to specialize were most of the recent graduates. Eleven per cent hoped to remain in government service.

Eighty Per Cent Seek Training

Eighty per cent of all medical veterans wish advanced training, about evenly divided between long-term opportunities to specialize and shorter review courses of more immediate value. Surgery, medicine and obstetrics and gynecology were the fields of preference, and New York, Boston and Chicago, the most popular graduate centers, Harold C. Lueth reported in the *A.M.A. Journal* on Aug. 19, 1944. Dr. Victor Johnson has estimated that 1600 will want surgical training and that 5727 will seek residencies and fellowships, to meet specialty board requirements, in a two year demobilization period.

The educational number of the *Journal of the American Medical Association* (Sept. 1, 1945) listed the expanded graduate opportunities. Residencies will be about doubled and short residencies now unapproved may be developed through affiliation with approved institutions.

The number of medical graduates available each year to fill future internships will depend upon three factors:

1. The flow of qualified students into premedical and medical schools.

Courtesy, Meriden Hospital, Meriden, Conn., William Rittase Photo.

Surgery, medicine, obstetrics and gynecology are the preferred fields.

2. The size of classes.
3. The timing and extent of curriculum deceleration.

There has been recent great and perhaps undue concern over the supply of premedical students. Before the Japanese surrender, a memorandum was submitted to President Truman on June 4, by a special committee of the Committee on Postwar Medical Service, consisting of Drs. Evarts Graham, Victor Johnson, Harvey Stone and Fred C. Zapffe, which estimated that 30,000 more physicians would be required in order to supply 15,000 to the Veterans Administration, 5000 to the peacetime Army and Navy, plus a possible 10,000 more if universal military training should be instituted. These figures did not include replacements of war losses, personnel assigned to medical assistance of liberated countries and personnel for the greatly expanded program of complete medical care visualized for this country.

Only 16,000 to Do Work of 30,000

It was calculated that 40,000 doctors would be graduated from 1942 to 1946, but that 24,000 practitioners would be lost through death over the same period, leaving a net gain of only 16,000 to do the work of 30,000. Hence, it was urged that every effort be made to ensure an adequate supply of premedical students, then menaced by the demands of Selective Service.

Although the termination of hostilities will do much to ameliorate the situation, we shall still be dependent upon Selective Service regulations, particularly if compulsory military training is adopted. To illustrate, discharge estimates for September called for 480,000 from the Navy and 500,000 from the Army, while during the same month 13,000 were to be drafted for Navy and Marine service and 50,000 for the Army. What effect these releases and drafts will have upon the supply of premedical students remains to be seen, but there should be sufficient number of students.

On August 27, Secretary Forrestal announced a further modification of the Navy plans, providing for the release of 2,900,000 men in the next twelve months to reduce the enlisted personnel to about 500,000. This is an increase over the original plan to release one and one half million during the same period. By Sept. 1, 1946, the Navy hopes to strip its requirements down to 58,000 officers and 500,000 men to maintain 400 war ships.

Until more definite facts are in hand, it seems most unwise to launch campaigns, such as that announced by Paul V. McNutt on August 21 to enroll 8000 veterans in medical and premedical schools and 4000 in dental and predental schools this year. The claim was made that the nation needs 35,000 more doctors of whom 15,000 will be required by the postwar armed forces, 15,000 by the Veterans Administration and the remainder for the service to liberated areas.

Since the annual output of all the medical schools in the United States up until the war was somewhat over 5000 graduates per annum, this total represents the normal seven year accomplishment of the largest medical educational resource in the world. Under the "forced draft" of the war-time accelerated curriculum with 10 per cent enlargement of classes, it was possible to turn out only 10,000 additional doctors in four years.

So much emphasis on numbers carries with it the danger of the fallacious assumption that *quantity* of graduates is more important in peace time than their *quality*.

Every consideration should be given to qualified veterans for entrance to future medical classes. As matters stand, however, the entering classes for the fall of 1945 are more than filled and the next opportunity will be in 1946. It is unfortunate to raise hopes for so many which cannot be realized at present except for those who may enroll in premedical courses.

Restore Three Year Minimum

A decision will probably be reached shortly to restore next year premedical requirements to the prewar three year minimum, the medical curriculum to its four calendar year length and residencies to their usual lengths. This will result, of course, in lowering the annual number of graduates.

The time will come when reduction in size of classes should be considered. Most schools find that the 10 per cent increases, introduced as a war measure, are beyond their capacity to handle efficiently. It is generally agreed that classes of 100 students or less are educationally desirable.

The misunderstandings apparent in these proposals, which fail to reconcile anticipated demands for medical service with the educational resources available, emphasize the importance of effecting closer working arrangements among educational

bodies, hospital organizations and governmental bureaus.

A step in this direction was taken last year by the formation of a conference committee with representatives from the American, Catholic and Protestant hospital associations, the Association of American Medical Colleges and the American Medical Association. Its purpose was to formulate plans for better cooperation in intern placement.

Faced with an acute intern shortage, resulting partly from war-time restrictions, hospitals and medical schools were drifting into chaotic competition. Following up an action by colleges interdicting the placement of students for internships until after the conclusion of the junior year, the new committee for the first time drew together the responsible medical educational groups of the country into a satisfactory working agreement. Representatives of interested governmental agencies might well be drawn into such working arrangements to guard against future misconceptions.

Cooperation Has Been Improved

Following the survey by the New York Committee on the Study of Hospital Internships and Residencies in New York City, 1934-37, the Association of American Medical Colleges set up a committee on internships, composed of the chairmen of the eight regions into which the country was divided. The consequence has been a greatly enhanced understanding of the educational opportunities offered by the hospitals through visits made by deans and faculty members to institutions where their graduates are interning.

One of the primary tasks before these coordinating and survey committees is to reconcile the house staff desires of the hospitals with the realities of supply. To a curious degree the rapid growth and multiplication of hospital facilities of recent years have not been accompanied by attempts to estimate potentialities as to the supply of house officers. The relative growth of these various factors may be illustrated by a table covering the two decades 1924-44 which appeared in the *Journal of the American Medical Association,* Aug. 19, 1944.

Naturally, hospitals offering internships and/or residencies approved by the A.M.A. Council on Medical Education and Hospitals will wish to lay their plans in accordance with anticipated demands. The annual quota of graduates will be temporarily augmented by the 12,000 returning medical officers who had from nine to twelve months' internship and approximately 2000 residents who did not have a chance to finish their training. Restoration of two year internships and full-scale residencies will be of assistance by reducing the number annually needed to fill quotas.

These reductions of demand on the one hand and increment of supply on the other may enable hospitals that saw their house staffs either seriously diminished or even wiped out during war time to compete again successfully with the larger institutions in the teaching centers—at least for a few years. Recent emphasis on the educational value of intern-

Increase in Numbers of Graduates, Internships, Residencies and Fellowships (1924-1944)

	Graduates	*Internships*	*Residencies and Fellowships*
1924	3562	3269	(Est.) 1000
1934	5035	6204	2375
1944	5134	5602*	5393*

*Both of these figures have been reduced by Procurement and Assignment restrictions. In 1943 the total number of internships offered had risen to 8180 and residencies and fellowships, to a total of 5857. These are an indication of what may be expected as soon as war-time controls are removed.

Courtesy, Hartford Hospital, Hartford, Conn., William Rittase Photo.

An estimated 1600 medical veterans will seek surgical training.

ships has had the effect of drawing graduates to the larger centers. As a counter measure, hospitals in smaller cities, to obtain more interns, must devise equally attractive opportunities for them.

Most hospitals will revert to the one to two year rotating, mixed and straight internships to which they are accustomed. The effect of the rapid growth of assistant residencies and residencies will be most felt among the two year internships, with the substitution of the senior intern year by one of assistant residency. An excellent compromise proposal is to divide the house staff during this second year, one half into senior internships as a preparation for general practice and the rest taking assistant residencies, and eventually residencies as a preparation for special practice.

Account will have to be taken of the trend to extend house staff service to private and semiprivate pavilions. War-time prosperity has had the effect of reversing the ratio of ward to private patients. This situation may be continued by the growth of Blue Cross and other prepayment plans. Hence, the teaching service of the future for students, interns and graduates must probably include an increasing number of private patients who, in turn, must be educated as to the benefit they receive from organized group study of diseases and their treatment.

Offer Extramural Residencies

Another important potentiality is the extramural residency, already given a thorough trial in Boston, Buffalo and Syracuse. It provides increased range of graduate opportunity and greatly assists in the task of introducing students and interns to the social and environmental problems they will encounter on setting up private practice.

Although form and schedule of internships and residencies are of educational importance, the type and quality of teaching provided are fundamental. For this purpose hospitals may be classified as follows:

1. *Teaching Hospitals for Undergraduates.*

A. *Major*—those with comprehensive programs applied to all services, with benefit to interns and residents, as well as the students.

B. *Minor*—those with a teaching affiliation to a limited degree, usually only for one service. The benefit that accrues to the house staff is highly problematical.

2. *Hospitals Approved for Internship and/or Residency, but Without Medical Student Teaching.*

3. *Postgraduate Hospitals.*

A. Teaching centers.

B. Small community hospitals.

Of recent years there has been a noticeable tendency for interns and residents to concentrate in the 1A hospitals at the expense of the 1B and 2 groups, because of the educational and research advantages offered. The standing of these major teaching hospitals has been enhanced by the introduction of a larger proportion of full-time and part-time teachers to round out the voluntary contributions made by attending physicians and surgeons.

Pay Full-Time Instructor

There seems no valid reason why hospitals in the second and third categories may not meet their tutorial obligations by the same maneuver. It should be possible to put on a salary one or more attending staff members with the proper qualifications and teaching interest to give full time or part time to organization and supervision of house staff educational needs. They can systematically review the interns' and residents' diagnostic findings and guide their case management.

Such teachers can maintain contact with university groups and carry this atmosphere into their own hospitals to round out educational contacts, instill a progressive spirit and stimulate original studies.

As will be seen by a perusal of the short courses listed by the A.M.A. for the present six months, teaching hospitals in groups 1 and 2 share widely in this postgraduate contribution which may have some secondary house staff benefit.

A large number of hospitals, however, are without undergraduate, internship or residency teaching of any kind yet constitute a vast potential resource for the furtherance of postgraduate education. Most are small community hospitals of 50 beds or less. With them rests the responsibility for realizing on the benefit obtained by staff members taking intensive courses at the postgraduate centers.

The Commonwealth Fund has taken the lead in exploring this possibility of educating the doctor in connection with his everyday practice activities centering around the small community hospital. As pointed out by Lester J. Evans in the *Journal of the Association of American Medical Colleges,* March 1944: "postgraduate teaching may be divided roughly into two kinds: one taking place in the physician's home setting; the other away from home, generally at a medical teaching center. Neither fills the bill by itself. They are definitely complementary."

The Bingham Associates Fund has made significant contributions in this same field through postgraduate opportunities at Tufts College of Medicine and the Joseph H. Pratt Hospital and a unique cooperative system with small hospitals in Maine, centering around key institutions in Lewiston and Bangor. This program was described by Samuel Proger in the *New England Journal of Medicine,* Sept. 4, 1941, and by various authors in The Modern Hospital of October 1944. This accomplishment has dramatized in effective and practical fashion the necessity of thinking beyond internships, residencies, fellowships and short courses at university centers as we evolve a full-scale program to meet the postgraduate needs of the American medical profession. Probably when plans are fully matured for other parts of the country, the experience available from the Commonwealth Fund and the Bingham Associates Fund experiments will serve as valuable blueprints.

Outlook Is Encouraging

Through the use of secretarial help, well-trained technicians, medical records auditing committees and staff conferences at which case findings and results are freely discussed, it has been shown that a voluntary attending staff in a small hospital can function at the same high level of efficiency as that of a university hospital.

If the majority of the smaller hospitals in the country could get over the defeatist attitude they have had concerning this possibility, we should attain the following far-reaching objectives: prevention of the wasteful lowering of professional standards of practice observable in fully half of our graduates after leaving teaching centers; an assurance of steady postgraduate progress, and a more uniformly high quality of medical service in all areas of the country.

NURSING

The nurses in service and the nurses behind the nurses in service merit our regard, our gratitude and our help

KATHARINE J. DENSFORD, R.N.
President, American Nurses' Association

THE hospital probably has as much at stake as any agency in the return of nurses from the war. Sixty-three per cent of the nurses assigned to the military as of July 1944 came from the field of institutional nursing, although in 1943 only 46 per cent of all active nurses were engaged in institutional nursing.

The 6611 hospitals in this country, with an increase of 80,691 beds, in 1944 cared for the unprecedented daily average of 1,299,474 patients as against 1,257,124 patients in 1943. They gave this care in 1944 with 125,458 graduate nurses (not including private nurses) as compared with 126,591 nurses in 1943, although the number of student nurses increased from 110,222 in 1943 to 120,879 in 1944.

Hospitals Still Need Help

When the Civilian Mobilization Program gets under way the theme of advertisers will be "Your Hospital Needs Help." In fact, the American Hospital Association's study estimates the number of nurses needed *now* by civilian hospitals—general, tuberculosis and psychiatric—at 65,000. And if needs for civilian hospital beds in the postwar decade are, as they have been authoritatively estimated to be, 279,000 beds, then the result will obviously be a growing demand for nurses in hospitals.

It is anticipated that the nonnursing duties carried by auxiliary workers during the war will remain in their hands, thus releasing nurses for professional and technical duties requiring the preparation of the registered professional nurse. In all probability most of the American Red Cross volunteer nurse's aides will drop out of hospital service, particularly the married ones who, often at real sacrifice, have served so faithfully during the war.

No attempt is being made to prepare additional volunteers but rather to get more trained aides into hospitals. Many paid aides of different types—attendants, practical nurses, orderlies and ward maids—will be employed in hospitals, in other institutions, in homes and in public health agencies, as will also some of those serving in the military, particularly those performing hospital duties.

A joint committee of all national nursing organizations has been studying the courses offered by the Army, Navy, Coast Guard and Maritime Service to train men and women in the military service for hospital duty. One of the reasons the study has been undertaken is to place material in the hands of state boards of nurse examiners and professional counselors that would make it possible for them to evaluate the qualifications of persons thus trained who may present themselves for examination and possible licensure as attendants or practical nurses.

It is contemplated that the completed study not only will provide an analysis of the course content for use by state boards of nurse examiners and nurse educators but also will offer suggestions concerning the possibility of establishing orientation courses at a number of hospitals sufficiently localized as to be accessible to as many applicants as possible to provide a transition from military to civilian activity. Benefits under the G.I. Bill of Rights may make it possible for applicants to take such courses.

Personnel policies are being studied by most professional groups, particularly those that have to do with working conditions and salaries. A joint committee of the American Hospital Association and the American Nurses' Association is currently at work on this subject. It is encouraging to find, as an editorial in the August 1945 issue of the *American Journal of Nursing* points out, that material tabulated by the A.N.A. from 14 state reports on personnel practices "reveals a high degree of unanimity on certain basic policies: (1) the eight hour day and forty-eight hour week with one full day off each week; (2) cash salaries without perquisites; (3) provision for definite increases in salaries within specified time limits and compensation (in time or money) for overtime."

Governmental Salaries Higher

Salaries of nurses in the federal services and in nonofficial public health agencies tend to be higher than those of nurses in nongovernmental hospitals. In general, salaries will probably be higher in the postwar than in the prewar period, though they will tend to conform to the social and economic pattern of the country as a whole.

The initial salary in 1945 in the Army and Navy Nurse Corps of $1800 plus subsistence and allowance would seem to serve as an index of beginning salaries in federal services. If civilian services wish to obtain quality nursing and nurses it is advisable that the salaries of nurses in civilian institutions parallel as nearly as possible those of nurses in the federal services.

Planning. The national nursing planning committee of the National Nursing Council for War Service, composed of representatives of all nursing groups, has developed "a comprehensive program for nationwide action in the field of nursing." Briefly, this program deals with five major subjects: (1) maintenance and development of nursing services in

This article was prepared prior to the end of the war with Japan.

all fields; (2) a program of professional and practical nursing education; (3) channels and means for distribution of nursing services; (4) implementation of standards (including legislation) to protect the best interests of the public and the nurse, and (5) information and public relations program.

Survey. The national nursing organizations, aware of the many factors making for change in postwar nursing, have undertaken a joint survey of their purposes, functions, structure and relationships to determine whether or not each organization is such as would make for effective handling of postwar programs.

Counseling and Placement. Withdrawal to the military of some 100,000 nurses from civilian nursing during the war has meant adjustment and readjustment all along the line, both by nurses in the military and by those in civilian services. The professional placement and counseling program of the American Nurses' Association, initiated in 1936, has been expanded to meet the needs for readjustment of all nurses, as well as for all other personnel that may be interested in nursing. The program operates through state nurses' associations.

Counselors Already Appointed

A national office, with one subsidiary branch office, will serve to coordinate the counseling and placement on national, state and local levels. Several states have already appointed well-qualified counselors, whose task in brief will be to help get the right nurse in the right job.

To aid in the counseling and placement, a questionnaire (sponsored by the American Red Cross Nursing Service and the A.N.A. and mailed by the Army Nurse Corps) has gone to all Army nurses and some 290,000 questionnaires had been mailed by state nurses' associations to civilian nurses as of August 1. Thousands of responses come in daily. Tabulation of the returns from these questionnaires, when completed, should give information regarding the postwar plans of most nurses.

This information will serve as a basis for much of the immediate counseling and placement work, both for the individual nurse in terms of her own preparation, experience, objectives and wishes and for the profession in terms of supply and distribution.

A tool of help to the veteran nurse will be found in a specially prepared pamphlet designed to assist her in adjusting to civilian life and shortly to be available. Among other things, this pamphlet will give information as to the nurses' rights and privileges under the G.I. Bill of Rights and vocational rehabilitation.

State counselors will be aware of these rights for veteran nurses, as well as the scholarship help for civilian nurses. They will know community needs and resources. They will have fairly complete information regarding the nurse (including that obtained from objective tests) and should be able to render increasingly effective service.

A note of caution might be injected here to warn us against expecting the millennium overnight. We must start with the counselors we have. Additional ones are being prepared as rapidly as possible. Fortunately, some 50 universities and colleges with schools of nursing already have courses in personnel work; scholarships are available for nurses who wish to take advantage of these opportunities.

Security. Questions are frequently posed about many kinds of security, among them provision for illness, accident, unemployment and old age. Many, if not most, nurses carry some protection in case of illness and accident. They are members of the Harmon Association for the Advancement of Nursing, which carries illness, accident and annuity benefits; or they subscribe to a group hospitalization plan, such as the Blue Cross. A very few look forward to pensions. Nurses have little protection, however, against unemployment and old age. It is these types of security, therefore, that merit our special consideration.

Many of the young people in our country entering nursing come from families of industrial workers and are accordingly familiar with the protections available to industrial workers, such as the benefits of the Social Security Act or of the labor unions. Nurses who have been in the military are familiar with the perquisites that go with military service. The coming generations of nurses will, I believe, place more emphasis upon such aspects of security as unemployment and old-age benefits than they will upon salary itself, important as income may be.

Just as farmers are now making an organized attempt to be included in the Social Security Act, so it seems to me must also the profession of nursing and those of us employing nurses in nonprofit agencies and as "casual labor" if we wish to retain nurses. There is no old-age security at present for nurses on salary, nor is there provision for funds when their salary stops.

The A.N.A. is working on the problem of attempting to find ways of obtaining provisions in the Social Security program that would make it possible for all nurses, including those in private practice, to receive unemployment and old-age benefits.

Further Preparation. The returning nurse will be a more mature person. She will be self-reliant. She will be aware of some of the pioneering needed in nursing and of the preparation required for this pioneering. While at first she will probably wish for little beyond just getting home, I predict that soon the returning nurse veteran, like her medical brother-in-service, will begin to look to wider horizons. She will have many skills and experiences she will wish to share with us, particularly in such fields as surgery and orthopedics.

Some Will Want to Study

Soon, a fair number of all returning nurses—perhaps from 10 to 35 per cent—will choose to pursue further study. Some of these will wish short refresher courses of from one to two weeks. Others may wish a longer period of perhaps four to eight weeks—a practicum—in which they can have both supervised experience and class work in a chosen field.

If nursing is to meet at all adequately its professional responsibilities, some of the returning nurses and some of the civilian nurses as well must undertake additional preparation not for weeks, or even months, but for one or more years. These are the nurses who will wish to strengthen their profession, who will wish to be really secure in their skills and to master the scientific knowledge of the underlying principles of these skills.

Many universities and colleges have programs already planned of refresher, practicum and advanced

(with or without practicum) types. Examples of advanced clinical programs designed to prepare nurses to give fairly complete and total nursing care in these fields may be seen in psychiatric and in pediatric nursing.

Legislation. Among the safeguards returning nurses will find is a profession well geared through its national, state and district associations to the sponsoring of legislative measures that concern nurses, nursing and health. Laws which the profession has recently supported are those that (1) increase the pay and allowances of the Army Nurse Corps; (2) provide for preparation of nurses through the U. S. Cadet Nurse Corps, with the first really large grant of public funds for nursing education, and (3) grant military rank to certain Navy Nurse Corps members and temporary commissioned rank to Army Nurse Corps members. Suggestions for major provisions of a nurse practice act and for organizing a legislative program have been prepared by the American Nurses' Association for the use of state associations in promoting legislation.

Research. Nurses coming back are returning to a profession equipped to conduct research in many areas of work. We have long had the efficient department of studies of the National League of Nursing Education. We now have, in addition, research workers in most of the national nursing organizations who are working in such areas as those of planning for postwar nursing, counseling and placement, community nursing service, civil service, prepayment health plans and social security.

Registration. Returning nurses will be pleased to know that the A.N.A. Bureau of State Boards of Nurse Examiners, in cooperation with the National League of Nursing Education, has served to bring about more uniformity in state laws, board rules and board procedure, all of which is greatly facilitating the distribution of nurses.

Public Information. To interpret nursing to a profession of more than a third of a million nurses in war time has been a unique and satisfying, though difficult, experience. That the interpretation has been well made is attested, among other things, by the more than 100,000 nurses who volunteered for military service. To interpret nursing to the lay public, as well as to nurses, has been and still forms a great challenge. Studies are now under way to find the best means of effectively reaching both groups in peace as in war.

There is one aspect of our living I should like to emphasize. This is the art of thinking. Young people who have spent months or years in a situation where so many decisions have had to be made for them (though in many cases they have carried great responsibility) must look forward to the time when they, as individuals, can do some thinking for themselves and can participate effectively in the formation of programs and policies. They must do this if our democracy is to continue.

To hospitals then is vouchsafed not only the opportunity but the responsibility of providing machinery through which all the nurses they employ may, as rapidly as possible, come to participate in the give and take of the democratic way of everyday living, to the end that, increasingly, they may become citizens not only of the hospital but also of the community, the state, the nation and the world.

The HANDICAPPED

disabled workers have good records

JACK MASUR, M.D.
Chief Medical Officer
Office of Vocational Rehabilitation

PHYSICALLY handicapped employes are good workers. There is ample evidence to prove that they have excellent records on job performance, little absenteeism, low turnover and few accidents. Disabled workers are conscientous and efficient employes who expect no favors.

The critical shortage of manpower in the war emergency forced all employers to reevaluate the work capacities of disabled persons. We have discovered that a disability need not debar one from productive usefulness in many occupations if the obstacles to employment are removed. Given equal opportunity, handicapped persons hold jobs better, with more mutual satisfaction, than does the average worker because they want permanence of employment.

With suitable modern methods of selective placement the majority of disabled persons can compete for jobs in industry and hospitals on satisfactory terms. Westinghouse Electric Corporation, Caterpillar Tractor Company, International Business Machines, R.C.A., Ford Motor and many other large and small companies have been employing handicapped workers successfully for many years. They have found that every job does not require a worker possessing the regulation two hands, two feet, two eyes and two ears.

Physical Demands Analysis

Job Title _____

Job Location _____

Dictionary Title _____

PHYSICAL FACTORS		ENVIRONMENTAL FACTORS	
__ 1 Lifting	__15 Twisting	__51 Inside	__65 Vibration
__ 2 Carrying	__16 Reclining	__52 Outside	__66 Noise
__ 3 Handling	__17 Sitting	__53 High Temperature	__67 High Places
__ 4 Pushing	__18 Reaching	__54 Low Temperature	__68 Cramped Quarters
__ 5 Pulling	__19 Fingering	__55 Sudden Temp. Changes	__69 Wet Quarters
__ 6 Climbing	__20 Feeling	__56 High Humidity	__70 Working With Others
__ 7 Jumping	__21 Talking	__57 Low Humidity	__71 Working Around Others
__ 8 Running	__22 Hearing	__58 Toxic Conditions	__72 Working Alone
__ 9 Walking	__23 Seeing	__59 Radient Energy	__73 Day Work
__10 Standing	__24 Color Vision	__60 Moving Objects	__74 Night Work
__11 Stooping	__25 Depth Perception	__61 Mechanical Hazards	__75
__12 Crouching	__26	__62 Electrical Hazards	__76
__13 Kneeling	__27	__63 Exposure to Burns	__77
__14 Crawling	__28	__64 Explosives	__78

(X = Required by job. O = Not required by job.)

DETAILS OF PHYSICAL FACTORS:

DETAILS OF ENVIRONMENTAL FACTORS:

DETAILS OF HAZARDS:

ing of jobs suitable for the handicapped has not proved a satisfactory method of job placement. The variations in interests, aptitudes and skills in disabled persons are as wide as they are in able-bodied persons. Modern methods of placement take into account many attributes of the prospective employe. The same selection factors should be applied regardless of whether the individual is able-bodied or handicapped.

Selective placement is a positive approach that utilizes the physical capacities of the individual instead of a medical diagnosis or the limitations of the disability. It is a placement technic by which the work demands of the job as determined by the job analyst are related to the work capacities of the employe as estimated by the physician.

The job analyst identifies the physical and environmental requirements of each type of job. The Civil Service Commission, the War Manpower Commission and industrial personnel

Hospital administrators have become increasingly interested in scientific employment methods. There has been a widespread use in hospitals of job analyses, including descriptions of duties, responsibilities, working conditions, necessary qualifications and personal relationships. There has been increasing recognition, also, of the values of instruction in job methods.

The selective placement method is an extension of the usual methods of job analysis and placement. It is the process of matching the worker with the job. As applied to handicapped persons the concept emphasizes "capabilities" rather than "disabilities." A disabled worker who is well placed is no longer handicapped. Banta and his associates[1] have pointed out that "a person with a disabled leg may be limited in his ability to walk rapidly, to run, lift or carry, but not in his ability to see, hear or use his hands. The disability does not limit his intelligence and educational achievements, vocational interests and aptitudes, nor need it affect his personality and work habits."

A fairly elementary approach to placement of the handicapped was a listing of suitable jobs. Such a list-

[1]Selective Placement for the Handicapped, War Manpower Commission, U. S. Employment Service, Washington, D. C., 1945.

Physical Capacities Form

Name _____ **Sex** _____ **Age** _____ **Height** _____ **Weight** _____

PHYSICAL ACTIVITIES		WORKING CONDITIONS	
__ 1 Walking	__16 Throwing	__51 Inside	__66 Mechanical Hazards
__ 2 Jumping	__17 Pushing	__52 Outside	__67 Moving Objects
__ 3 Running	__18 Pulling	__53 Hot	__68 Cramped Quarters
__ 4 Balancing	__19 Handling	__54 Cold	__69 High Places
__ 5 Climbing	__20 Fingering	__55 Sudden Temp. Changes	__70 Exposure to Burns
__ 6 Crawling	__21 Feeling	__56 Humid	__71 Electrical Hazards
__ 7 Standing	__22 Talking	__57 Dry	__72 Explosives
__ 8 Turning	__23 Hearing	__58 Wet	__73 Radiant Energy
__ 9 Stooping	__24 Seeing	__59 Dusty	__74 Toxic Conditions
__10 Crouching	__25 Color Vision	__60 Dirty	__75 Working With Others
__11 Kneeling	__26 Depth Perception	__61 Odors	__76 Working Around Others
__12 Sitting	__27 Working Speed	__62 Noisy	__77 Working Alone
__13 Reaching	__28	__63 Adequate Lighting	__78
__14 Lifting	__29	__64 Adequate Ventilation	__79
__15 Carrying	__30	__65 Vibration	__80

Blank Space = Full Capacity ✓ = Partial Capacity O = No Capacity

May work _____ hours per day _____ days per week. (If TB, cardiac or other disability requiring limited working hours.)

May lift or carry up to _____ pounds.

Details of limitations for specific physical activities _____

Details of limitations for specific working conditions _____

Date _____ Physician _____

departments have analyzed many thousands of job types from the point of view of physical demands.

The analysis of physical activities and working conditions of the relatively small number of job types in the hospital field is a challenging opportunity and is a logical sequence to the excellent studies of Gorgas, Meade and Stephan[2] on job specifications. In most offices of the U. S. Employment Service, personnel is available to assist any hospital in the training of its personnel officer or other staff member in the technics of job analysis. In analyzing the physical demands of each job, the analyst uses the accompanying form. The dictionary title and code refer to the Dictionary of Occupational Titles.[3] It is to be noted that the physical factors and environmental factors listed are identical with those on the Physical Capacities Form used by the physician.

Aids in Determining Eligibility

Many hospitals, large and small, have found it advantageous to appoint a member of the medical staff to examine applicants for employment. Under such circumstances the adoption of the physical capacities appraisal method is an improvement in the usual procedure of using medical diagnosis as the determination of eligibility for employment. The Physical Capacities Form can be completed from data on the physical examination findings.

In industrial practice, such as the Kaiser-Permanente shipyards hospitals,[4] it has been found preferable to furnish the personnel office with the physical capacities appraisal only and thus avoid revealing the confidential medical diagnosis.

The physical factors and environmental factors listed on these forms were designed by the War Manpower Commission for the use of industry. The number of items could undoubtedly be reduced and simplified for hospitals interested in placing workers selectively in accordance with their skills and physical capacities.

The handicap of disablement should not be made worse by lack of understanding or prejudice, and a resultant lack of opportunity to compete fairly for employment. In order to obtain for disabled persons their full share of opportunity within their capacity for normal employment ordinarily available in the labor market, we should encourage the good will that now exists among employers toward all persons, civilian and veteran, handicapped by disablement. It is generally agreed in this country that the assimilation of disabled veterans into industry should be on a voluntary basis rather than by legislation.[5]

Employers need to be reassured that under suitable conditions disabled persons can serve effectively without hazard to themselves or others. A bulletin issued by the Association of Casualty and Surety Executives[6] encourages member companies to promote the employment of disabled persons. This statement points out that the initial rate for workmen's compensation is governed by the industrial classification. Physical defects of disabled persons are not considered in determining that rate and no higher rate is charged to the employer because of the employment of physically disabled persons.

The employment of disabled persons is not prohibited in any way by the terms of workmen's compensation insurance policies. Accident experience, good or bad, will ultimately be reflected in the cost of insurance, but most surveys have shown that physically handicapped persons have fewer accidents than do able-bodied employes.

In the infrequent cases in which handicapped persons sustain serious accidents that result in permanent total disability, the employer is confronted with a disproportionate liability. In order to minimize this liability to the employer, to spread the cost over industry generally and to assure payment of full compensation to handicapped workers, laws have been enacted in 32 states[7] to establish second injury funds[8] or their equivalent.

The veterans' employment service of the War Manpower Commission and the state vocational rehabilitation agencies are eager to cooperate with hospitals in the placement of disabled persons. The goal of every rehabilitation program is to fit the handicapped worked into a job where he is productive and where his earning capacity lifts him from the status of an economic cripple.

Give Them Help, Not Handouts

The number of disabled persons seeking employment will be greatly increased by the returning veterans. It has been estimated that every fifth family will include a disabled worker, often the one who would normally be the breadwinner. The adjustment of all disabled persons is a joint responsibility of government, management, labor and local communities. The answer lies in adequate vocational rehabilitation and sound placement in employment—not in pensions, public assistance and handouts!

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[2]Job Specifications for a Housing Organization, Committee on Personnel Relations of Council on Administrative Practice, Bulletin No. 202, American Hospital Association, Chicago.

[3]Dictionary of Occupational Titles, War Manpower Commission, Superintendent of Documents, Washington, D. C.

[4]Physical Demands and Capacities Anaysis, Limited Issue by Region XII, War Manpower Commission, Bureau of Manpower Utilization, and Permanente Foundation Hospitals, Oakland and Richmond, Calif., May 1944.

[5]The Disabled Veteran, Annals of the American Academy of Political and Social Science, Vol. 239, May 1945.

[6]The Employment of Disabled Veterans and Other Disabled Persons, Association of Casualty and Surety Executives, 60 John Street, New York City.

[7]Me., Ariz., Ark., Calif., Colo., Conn., Del., Ida., Ill., Iowa, Kan., Md., Mass., Mich., Minn., Mo., N. J., N. Y., N. C., N. D., Ohio, Okla., Ore., Pa., R I., S. C., Tenn., Utah, Wash., W. Va., Wis., Wyo.

[8]Second Injury Funds as Employment Aids to the Handicapped, Division of Labor Standards, U. S. Department of Labor, Washington, D. C., 1944.

Untapped Manpower: Facts and Figures on Employment of the Physically Handicapped, Washington, D. C., U. S. Civil Service Commission, Superintendent of Documents, Government Printing Office, Washington, D. C., 1943.

Selby, C. D., et al.: Putting the Disabled Veteran Back to Work, New York, Industrial Hygiene Foundation, 1943 (Special Series Bulletin No. 2).

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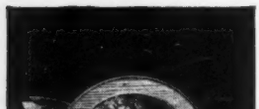

PHARMACY *After* Demobilization

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THE pharmacist who has served in the armed forces naturally is interested in the opportunities that may be available to him within his chosen profession after demobilization. Many will wish to enter various areas of pharmaceutical practice. Some will wish to enter retail, wholesale or manufacturing fields; others will wish to prepare for research and teaching. Some who have served in fields unrelated to pharmacy may wish to adopt a completely new profession. Many of those who have served in hospital and medical units will wish to select hospital pharmacy as a life work. It is for this last group that this paper is written.

There can be no doubt that pharmacy will be used more extensively as one of the most important therapeutic facilities after demobilization. This increased use will not come about suddenly but there are several straws in the wind that indicate the trend.

The Situation. Data published in the *Journal of the American Medical Association* reveal that there were 1864 government and 4494 nongovernmental hospitals (total 6358) serviced by 2382 full-time and 497 part-time pharmacists in 1941. In 1943, there were 2284 government and 4371 nongovernmental (total 6655) hospitals serviced by 3563 full-time and 605 part-time pharmacists.

Many Have No Pharmacy

These data show that there are more than 2487 hospitals without any real pharmaceutical service, since we know that many large hospitals engage a number of pharmacists on their staffs. Many other hospitals are inadequately staffed. The number of hospitals and pharmacists serving the armed forces is not taken into consideration in these figures.

Adequate pharmaceutical service would require twice the number of pharmacists engaged in hospitals at the present time. Plans for the expansion of hospital facilities by the federal, state and municipal agencies to care for the needs of veterans and for the extension of medical care to all the people are so great that it appears evident that there will be a need for a further increase in pharmaceutically trained hospital personnel to serve the needs during the next five years; in other words, from 12,000 to 18,000 hospital pharmacists will be needed by 1950.

Drugs Play Important Rôle

Drug therapy is more important than ever before in mankind's fight against disease. The sulfa drugs, the antibiotics and blood plasma are examples of preventive and curative agents that have renewed our faith in drugs. Other equally spectacular and effective agents will be discovered through the intensive research now under way.

The Trends. Progressive hospital administrators have learned that a well-established pharmacy contributes immeasurably to medical care in the hospital and also to economy. Nevertheless, thousands of hospitals are operating with insufficient, incompetent or unqualified pharmaceutical staff members. This situation needs to be corrected in simple justice to the patients. Improvement is being made, however, as evidenced by the following changes.

The U. S. Public Health Service under the law (S. 1683) which codifies all laws relating to the service has provided recently for increased opportunities for pharmacists. Now they may be commissioned in the regular corps beginning with the rank of junior assistant grade, which is comparable to a second lieutenant in the regular Army, and they may advance on the basis of experience and examination to a rank comparable to that of colonel in the same manner as officers of the Medical Department.

The position of pharmacists in veterans' hospitals has been greatly improved. Effective July 1, 1945, all pharmacists were advanced to professional and scientific grade 2 with a salary range from $2600 to $3200 per year. In the past the pharmacists were classified as subprofessional with starting salaries as low as $1620 per year.

This recent change represents a definite recognition of the professional status of the pharmacist. The expected expansion of veterans' hospitals will necessitate additional pharmacists. Those interested should write to the Director of Personnel, U. S. Veterans Administration, Washington, D. C.

Work to Advance Profession

Two organizations have been developed that should serve to create unity among hospital pharmacists and lead to better service, namely, the American Society of Hospital Pharmacists affiliated with the American Pharmaceutical Association and the American Association of Government Pharmacists, which is now in process of organization.

Both of these organizations have as their objectives the improvement and the extension of the usefulness of hospital pharmacists to the institutions, to the profession of pharmacy and to the members of the other health professions. Coordination of the work of these organizations with that in all pharmaceutical areas through the American Pharmaceutical Association augurs well

for the future outlook. (See Francke, Jour. Am. Pharm. Assoc., Pract. Pharm. Ed. **6:** 77 [1945]; Moore, Am. Prof. Pharmacist **11:** 442 [1945]).

It was almost two years ago that Congress passed a bill to create a pharmacy corps in the regular Army. Little has been done to make this legislation effective. (See Einbeck, Am. Prof. Pharmacist **11:** 527 [1945]).

Qualifications and Responsibilities. The hospital pharmacist needs special qualifications for his work. These may be stated briefly as follows: administrative and organizing ability; the capacity to serve with others in a complex organization; good physical and mental health; knowledge of his subject acquired through specialized college training, preferably including graduate work, and teaching ability and experience. (See Francke, Mod. Hosp. **62:** 90 [Jan.] 1944).

Must Accept Responsibility

He must be qualified to accept responsibility for an integral part of the hospital service, for the maintenance of proper relations in his own department and with the hospital staff, for the manufacture of products and for teaching student nurses and pharmacist assistants; he must be competent to advise physicians in all matters that pertain to drugs. Ability to conduct and supervise research will be of great value to the hospital pharmacist of the future.

The General Outlook. Although there are many discouraging factors facing those who wish to pursue hospital pharmacy as a life career, the trend is upward. Veterans who have had valuable experience in the armed forces and who have the necessary educational qualifications may expect to find that hospital pharmacy is an expanding field of opportunity. They can assist in making it attractive by uniting with other pharmacists to bring greater professional competence into the practice and by seeking to elevate the standards.

Adequate pharmaceutical service can be an important means of providing more efficient medical care at lowered cost to our citizens. At this time when all health service is in the process of reorganization the outmoded dispensing service of the past should be replaced by modern standards of practice.

Occupational Therapy

is coming into its own

GERALDINE LERMIT
Director, St Louis School of Occupational Therapy, St. Louis

A TURTLE for a symbol and the slogan "Slow and Steady" might best describe to the civilian and perhaps to the veteran the plan of the Veterans Administration for acquiring personnel for occupational therapy and rehabilitation in its hospitals. Nevertheless, plans have been made for acquiring occupational therapy and rehabilitation personnel and for its training and are now being put into motion.

For those already in this field, excellent refresher courses have been given by the Veterans Administration at the Institute for Crippled and Disabled. These courses are similar to those that were given to members of the medical staff of the Army Air Corps, under the guidance of Col. Howard Rusk.

Centers for training additional personnel are now being selected and special veterans' hospitals are being used as key centers for in-training programs. It seems evident that the Veterans Administration is making a genuine effort to profit by the experience of the military reconditioning program.

Acceleration is definitely indicated but will probably prove more difficult to effect now than it was under the urgency and stress of war. But the approach of the Veterans Administration in planning to fill this need seems thoroughly sound.

There is no clear indication as to whether the scope of the problem of obtaining and training personnel is fully realized, unless the latest announcements that only veterans will be placed in civil service jobs can be so considered. Although the need is long overdue, civil service is now reclassifying and rerating occupational therapists. It is becoming apparent that professional classification is indicated by the nature of the service itself, as well as by the standards for meeting educational and training requirements.

If occupational therapists are put under "professional" status, there will unquestionably be more and better qualified individuals attracted to fill the needs of the Veterans Administration. Even more than the monetary increase provided by such reclassification, the acknowledgment of the essential need for the services rendered by occupational therapy and rehabilitation will undoubtedly act as a magnet in drawing the required personnel not only from the ranks of the civilians but from those of the returning veterans.

Experience Has Taught Them

It is surprising how many of these men and women have already expressed interest in this tangible aspect of rehabilitation. This interest seems to have grown naturally from their own experiences and observations rather than through any planned guidance. However, some of the guidance counselors have steered inquirers to schools and colleges. Many of those who have seen service, *i.e.* medical corpsmen and hospital aides, have realized the essentiality of this simple therapy and its effectiveness. They have had frequent opportunity to observe the results of the wholesome therapy of "work and play."

The Veterans Administration is gearing up to meet the needs of its patients in occupational therapy and rehabilitation. It may be slow, but nevertheless it is steady and it would be well to remember before making unconsidered criticism that even the largest turtle has a very big and heavy shell to carry on its back.

REHABILITATION
Centers in the Hospital

LEO M. LYONS
Director
St. Luke's Hospital, Chicago

JOHN S. COULTER, M.D.
Director
St. Luke's Hospital Rehabilitation Center

TWENTY-FIVE years ago, in 1920 to be exact, St. Luke's Hospital, Chicago, took the first steps toward the development of a physical therapy department. This start was made under the direction and leadership of Dr. Harry E. Mock who gave unselfishly of his time and energy. A year later the woman's board of the hospital accepted as one of its primary functions the financing of this program and has continued to carry this responsibility throughout the intervening years.

The establishment of this department was a pioneering job and was perhaps an outstanding example of coordinated effort on the part of lay and professional people in meeting the needs of the physically ill.

Plan for Convalescence

Every large hospital should make some provision for the rehabilitation of manpower which has been so vitally affected as the result of total war. It is not sufficient for the practitioner or surgeon to guide his patient through the acute stages of his malady or injury; his convalescence must also be planned and, through skillful guidance, be shortened in every way possible.

As we look ahead, many of our former industrial workers will return as veterans of this war and if they are injured they will need treatment in civilian hospitals comparable to that which was given them in the Army and Navy hospitals and which will continue to be given by the Veterans Administration.

Insurance companies are beginning to recognize the need for this service and the Liberty Mutual Insurance Company, now writing a substantial volume of workmen's compensation, recently established its own rehabilitation center in Boston. Dr. Alexander P. Aitken, who is in charge of this clinic, states that although it is still in the experimental stage, the staff members are highly gratified with the results that have been attained. It is probable that the care of the industrially disabled can be vastly improved in large hospitals if there is added to the physical therapy department a well-organized and well-conducted work therapy department.

S. Bruce Black, president of the Liberty Mutual Insurance Company, in discussing this matter stated: "Our experience has been that there was considerable difficulty about full recovery or restoring the worker to a working status in some cases. The establishment of our rehabilitation clinic and pilot clinic was an effort to find a remedy for this situation." After this clinic had been in successful operation for a year, Mr. Black expressed the opinion that rehabilitation should begin as soon after the injury as possible.

Lt. Col. Raymond Hussey, formerly chairman of the committee on occupational diseases of the Maryland Department of Labor, and chairman of the committee on workmen's compensation of the A.M.A. Council on Industrial Health, made this significant statement: "It is unfortunate, I feel, that physical and occupational therapy clinics are organized separately from hospitals, since we all realize that physical and vocational rehabilitation procedures should be given simultaneously with medical and surgical treatment."

In order that this theory might be thoroughly tested and so that undergraduate and postgraduate students could be taught these general principles, the Liberty Mutual Insurance Company gave to Northwestern University the sum of $10,000 in order that this theory of combining hospital and rehabilitation center could be carried out. Northwestern University selected St. Luke's as the proving ground and, in turn, allocated a portion of the grant to the hospital.

Department Well Laid Out

A study of facilities at St. Luke's emphasized the wisdom of this selection, as it was possible to enlarge our occupational therapy department and keep it in close proximity to the physical therapy department, a necessary and desirable relationship. This was accomplished by using an area which had in years past served first as a surgical ward and later as an employes' dining room.

This room was large, well lighted and ventilated, with a high ceiling, and was easily connected with the physical therapy department by the construction of a steel stairway. This stairway was broken into units—five steps, a rest landing and then six more steps—and was equipped with hand rails. This stairway in itself is a valuable asset in our therapy treatments. (Fig. 1.)

By correlating our physical and occupational therapy facilities and after staffing our physical therapy department with four registered therapists, we experienced consider-

St. Luke's Hospital herewith acknowledges its indebtedness to Liberty Mutual Insurance Company for the establishment of a rehabilitation clinic in Boston and is glad of its opportunity to have had a definite part in the rehabilitation of those who suffer physical handicaps.

able improvement in the operation of the program. It is essential that well-trained personnel be used in this department because of the need of this training and experience in the administration of correct physical therapy and because, whenever possible, treatment should be given while the patient is still confined to his bed.

One important piece of equipment in the physical therapy department is the apparatus which makes underwater exercise possible; therefore, we equipped the department with a stainless steel Hubbard tank which was made from a design furnished by the Council on Physical Medicine of the American Medical Association.

This apparatus is equipped with an overhead track conveyor for transferring patients from the stretcher to the tank by the use of a canvas and metal frame. By the use of this equipment patients with infantile paralysis, generalized arthritis, spine fractures (with and without spinal cord injuries), fracture of the upper end of the humerus, fractures of the pelvis and fractures of the femur can be given early exercises.

We obtained a portable whirlpool bath which is used to give heat and hydro massage and underwater exercise for leg, knee, ankle, foot, elbow, forearm and hand.

The department has seven treatment rooms available. These are equipped with tables and mattresses that are approximately 30 inches wide, 30 inches high and 6½ feet long and, in addition, there is one small hand treatment table. This equipment was made in the shops of the hospital.

The rooms are equipped with exercise apparatus—Kanavel table, stall bars, shoulder wheel, adjustable parallel bars. Much of this equipment was made by the hospital carpenter from specifications furnished by the Council on Physical Medicine.

This department is also supplied with one ultraviolet lamp, three large and three small infra-red generators, three large and three small electric lamp bakers, three rhythmic constrictors, one Bristow coil, one galvanic generator and one paraffin bath.

The occupational therapy department staff consists of three registered technicians; in addition, students

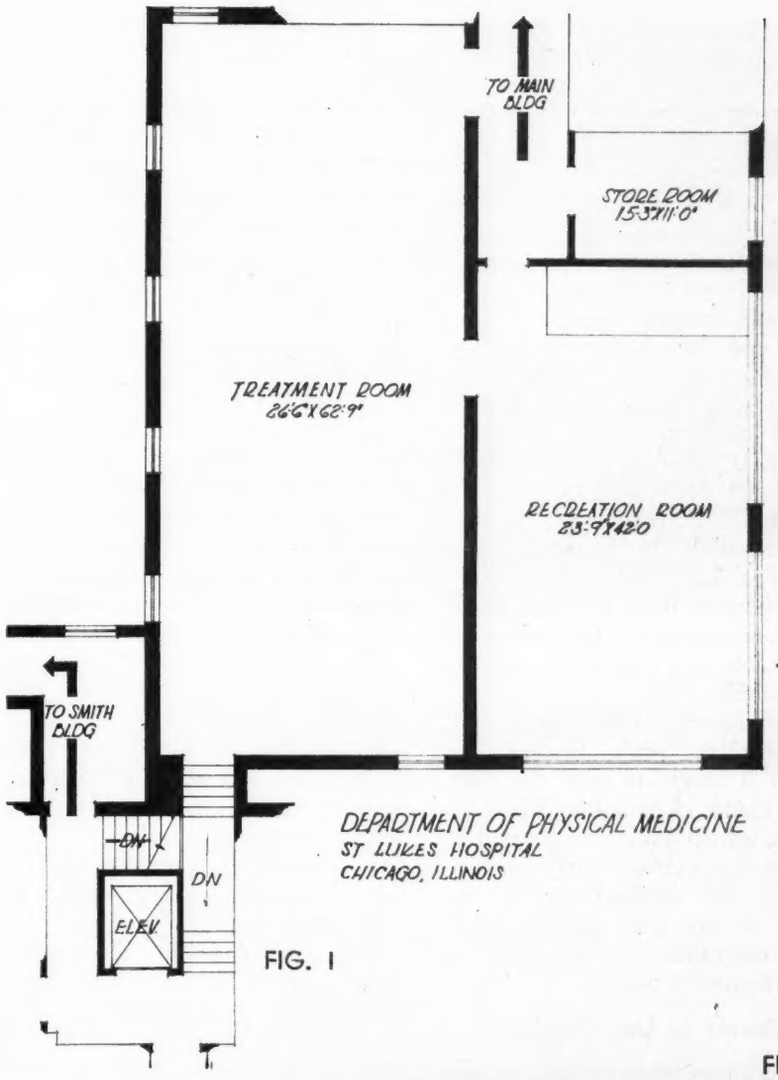


FIG. 1

FIG. 2

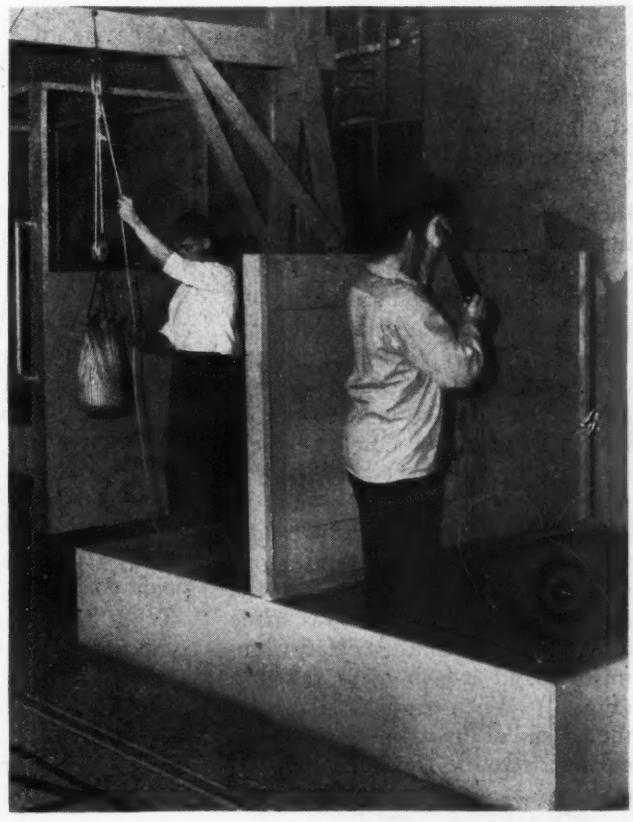


Fig. 1: Plan of the occupational therapy department showing stairs connecting this department with the physical therapy department. Fig. 2: Gravel pit and scaffold with a pulley and sandbags by which weight can be varied. Both of these are used to test the patient's ability to labor.

from various accredited schools of occupational therapy render valuable service.

This department has three rooms: a workshop, 28½ by 62½ feet, a recreation room, 23 by 42 feet, and a small storeroom which is used to store apparatus and odds and ends of lumber. This space is approximately 11 by 15 feet. (Fig. 1.) The workshop is equipped with a bicycle lathe and two bicycle saws, one treadle saw and one treadle sander (built by the occupational therapy department from parts of old sewing machines), a scaffold with adjustable pulley for weight lifting and a partitioned gravel pit which was constructed by the hospital carpenter. (Fig. 2.)

In addition, there are three standard work benches, a tool cabinet, a paint table and two hand and two foot looms.

In addition to instructing in exercise through work therapy, the patient is taught to meet the physical demands of daily life. These demands, usually taken for granted by the average person, often loom so large to the disabled that his inability to cope with existing conditions constitutes a serious threat to his independent action.

Taught to Use Crutches

Many times when patients are discharged from a hospital they are walking on crutches without much preliminary experience. At St. Luke's this instruction is started early by giving psychological and physical preparation in the use of crutches while the patient is still sitting on the bed. At that time crutches are fitted and the beginning of crutch walking on the level floor is started.

Crossing a street on crutches, with the traffic stopped but likely to start with traffic lights, presents to the patient a definite psychological and physical hazard. To meet this problem the patient is taught to step down from a 9 inch curb and to walk 60 feet, which is the width of Michigan Avenue, timing his action with a standard automatic street signal that has been installed in the department. This signal was made available by the Chicago Safety Commission and is extremely valuable. (Fig. 3.) When the patient reaches the far end of the room, or the width of the street, he steps up onto the curb.

To train a patient with crutches to get on and off the streetcars, we obtained, through the courtesy of the Chicago Rapid Transit Company, a standard streetcar step, handles and all, which had been mounted on a platform of standard height so that the patient learns by practice to get on and off transportation equipment. (Fig. 4.)

We believe that an adequate hospital rehabilitation center depends upon proper personnel, proper equipment, good location and complete coordination between the occupational and physical therapy departments of the hospital. Standards of care and treatment should be safeguarded by the employment of highly competent workers and by the appointment of a physician as director of the department.

The department should be staffed by registered physical therapists and registered occupational therapists who can well be supplemented by students in each field. We realize, however, that it will be some time before a sufficient number of physicians specializing in physical therapy will be available to take charge of such departments.

Full cooperation by all hospital departments is essential to success because every patient referred to the department is under the care of the attending physician who first treated him for injury.

The referral of a patient is accompanied by a requisition signed by the attending physician outlining the objectives which he wishes to attain. The charges for physical therapy and occupational therapy are determined by the type of treatment and the time required to give this prescribed treatment and, in many cases, combine both physical and occupational therapy.

The basic charge for occupational therapy is 50 cents for the first hour and 25 cents for each additional hour or major portion thereof.

When occupational therapy is received without physical therapy the charge is $1 for the first hour and 50 cents for each additional hour or major portion thereof.

While few general hospitals have combined physical therapy and occupational therapy in forming rehabilitation centers, we feel that only by this method can the patient receive whole-time treatment as an in-patient or an out-patient. Treatments must

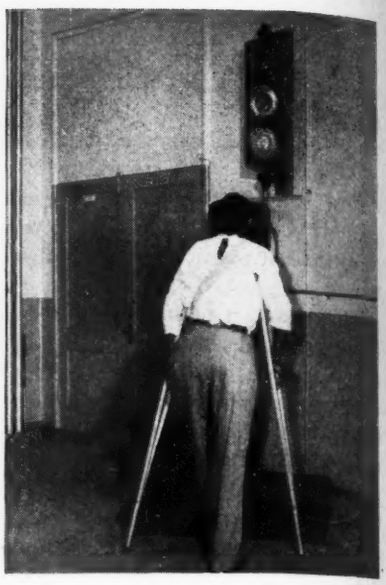


FIG. 3

Fig. 3: Street signals and curb. For photographic purposes the imitation curb is placed near the signal instead of 60 feet away.

be such that the patient's interest is sustained from the beginning to the end of the treatment period, as well as for the over-all length of the treatment.

In considering patients who ultimately must go back to heavy work, there is a gradual program of occupational therapy that conditions his entire body. At the same time, the patient who is normally employed at sedentary work requires treatment that will relieve him from the heavier duties designed for the rehabilitation of the laborer.

Pain and Fear Eliminated

In this center we endeavor to eliminate as much as possible the individual's pain and fear and to keep fatigue at a minimum. Pain is lessened by the cooperation between the hospital staff and the physical therapy department. The advantage of having the workshop near the physical therapy department is apparent, for by use of heat, diathermy, whirlpool bath, massage and muscle stimulation, the pain is diminished and exercise is facilitated.

By cooperation of the occupational therapy technicians and the patient's employer, fear as to the hazards of the job and to future employment is kept at a minimum and the confidence in the attending physician is greatly strengthened.

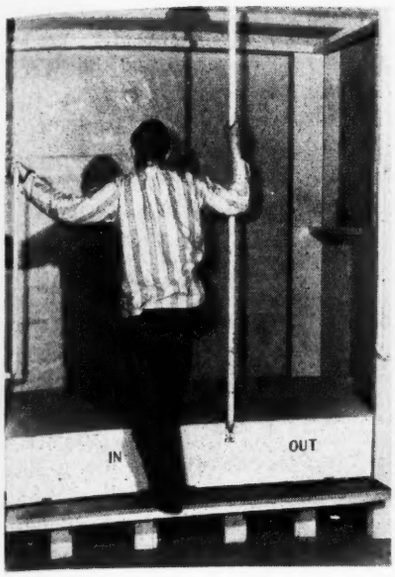


FIG. 4

Fig. 4: Real streetcar steps, complete with handles, help patients learn to get on and off of streetcars in safety.

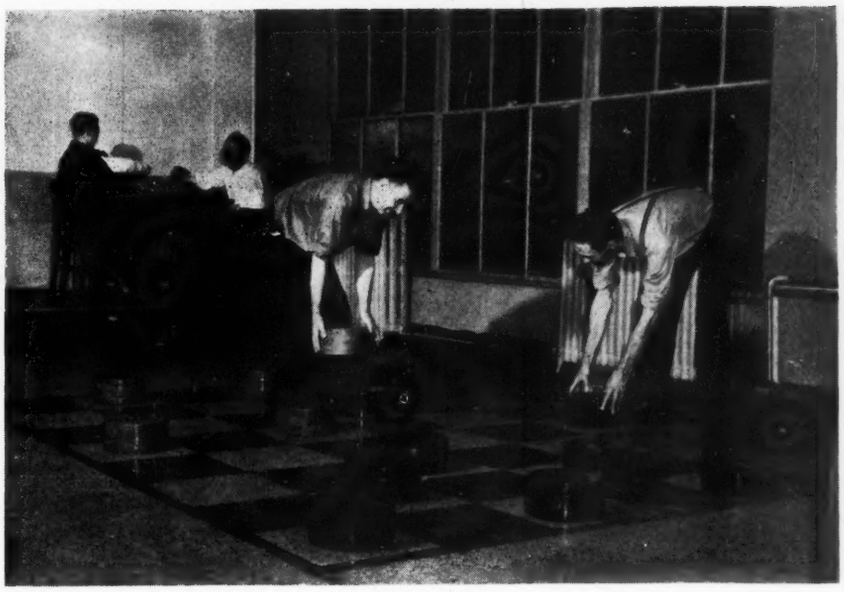


FIG. 5

Fig. 5: Recreation room, showing the floor checkers game. Floor checkers affords exercise for the back and for inversion and eversion of the ankles. In addition, there are a wall checkers game, darts board, table hockey, indoor and outdoor shuffleboard court and horseshoe pit.

The primary object of this department is to rehabilitate the patient; therefore, the physician in charge of the department is cautioned against giving testimony regarding the patient's condition to insurance companies, to the employer, to the court and to the workmen's compensation board. One report given too early in the patient's period of recovery can be misinterpreted to mean that the department is trying to get the patient back to work for the benefit of the insurance company instead of having the patient's welfare at heart. Such news spreads rapidly and creates fear in other patients with the resultant loss of confidence in the department.

Recreation Is Therapy, Too

To guard against fatigue the patient is cautioned that exercise, whether work or play, should consist at first of relatively short periods. It is recognized that fatigue may be mental as well as physical; therefore, recreational therapy is an important adjunct to this program. Recreational therapy, which is a form of occupational therapy, can be arranged to give desired exercise through the placing of special equipment.

In this department we have a pool table and a ping-pong table; these provide walking exercise, exercise of the hand and arm and general coordination through recreational activities. In addition, we have floor checkers for back exercise, for inversion and eversion of the ankle (Fig. 5); a wall checkers game and a darts game for shoulder, arm and hand action; table hockey for supination, pronation and general coordination, and many other table games for intrinsic movements of the hand.

Besides these we have an indoor and outdoor shuffleboard court, as well as a horseshoe pit, which are used for shoulder, arm and general body exercise.

Another function of the recreation room is its contribution to the much-needed social adjustment of the patient. It has been found that in the treatment of the injured man social adjustment often must come first, that although many hours and days are spent in training a man vocationally if he is not able to achieve his proper place socially he will never be satisfactorily rehabilitated.

The patient must acquire ease in conversation with his fellows and be able to participate in the type of game or activity that is generally accepted. Games are played with and taught by the technician or student and are conducted in such a manner as to encourage the patient to excel so that he will regain confidence and social poise.

To cite an example, a man with an artificial hand came to the rehabilitation clinic and although we were able to get him to use that hand and arm to saw wood, hammer nails and do an acceptable job in the woodworking shop, he was not at ease and would keep his hand, when it was not in use, stuffed down into his pocket. It was not until he had found by experience that he could play pool well that he realized that even with such a hand he could equal or excel an uninjured person in a pastime.

Coordination of Effort Counts

Rehabilitation of injured persons requires prompt and efficient use of physical medicine as represented by coordinated physical, occupational and recreational therapy and, to us, this means the establishment of rehabilitation departments in both new and existing general hospitals.

HOW MUCH Should Blue Cross Pay to Hospitals?

EVERETT W. JONES

BECAUSE the enrollment in Blue Cross plans has increased rapidly and because hospital costs have been mounting during the war period, there have broken out in various places fairly vigorous discussions of the rates of payment by plans to hospitals.

In these discussions, which in a few instances have been almost acrimonious, we must not throw out the baby with the bathwater. We must keep constantly in mind the great common purpose of both hospitals and plans, namely, to give the best possible service to the American public at the least possible cost.

We can avoid much of the acrimony by keeping the welfare of the public always in mind as our No. 1 goal and by careful studies that will give everyone concerned a clear picture of the whole situation and of the probable effects of wider, more comprehensive contracts.

Hospitals' Fair Share

Hospitals, obviously, must receive enough money in total to pay their total expenses. So far as Blue Cross patients are concerned, hospitals should be paid enough to meet their costs for these patients plus, for those hospitals that actually do charity work, something additional to help pay for the free service. This plus factor should be retained only so long as necessary. As soon as possible, hospitals should receive from 75 to 90 per cent of the cost from governmental agencies for the care of indigent and medically indigent patients. They should now receive cost plus 10 or 15 per cent for workmen's compensation patients. When cost is received for the care of all such patients, the plus factor might well be dropped from Blue Cross payments.

In studying this matter all Blue Cross executives and directors and all hospital administrators and trustees should be acquainted with the following six sets of figures:

1. What are the total billings for day rates plus average billings per day for extras for patients paying their own bills to each of the following categories of patients (excluding billings to clinic patients and ambulatory private pay cases): private room patients; semiprivate room patients; self-pay ward patients.

2. What percentage of these billings is actually collected in normal times? The years 1941 and 1942 might be considered normal.

3. What is the average amount of accounts receivable carried on the books for these patients and what is the annual cost to the hospital for interest at, say, 4 per cent on this amount?

4. What is the average cost per patient per day for "in bed" patients (excluding cost for services rendered to clinic out-patients and private pay ambulatory patients) as computed according to the American Hospital Association's chart of accounts given in the 1940 edition of "Hospital Accounting and Statistics"?

Note particularly these statements in the manual: "The operating expenses include . . . allowances for depreciation (replacement) of fixtures, equipment and scientific apparatus" (p. 17). "The nonoperating expenses (group 2) are not incurred in all institutions. They include expenses of nonhospital services, interest on borrowed funds, depreciation on buildings, taxes, and rentals. . . . This does not mean that nonoperating expenses are not a part of the costs of hospital service but merely that they should be carefully segregated in all comparisons of operating expenses" (p. 18).

"In this account [depreciation of equipment and fixtures] are recorded estimated amounts for each major class of fixtures, furniture, equipment and apparatus. The amount of depreciation is recorded and reported as operating expense. Annual rates of depreciation for the various classes of equipment are suggested in part VI."

5. What is the average income to the hospital per patient per day for patients covered by the Blue Cross (for items covered under the contract) from the plan, plus income for items (not covered under the contract) from the patient for:
   a. Private room patients
   b. Semiprivate room patients
   c. Ward patients?

6. Improvement in hospital income and financial position owing to: number of Blue Cross patients who would have been in the member hospital or county hospital as outright charity (free) patients if they were not covered by a Blue Cross contract; number of Blue Cross patients who would otherwise have been in the member hospital as part-pay ward cases and on whom the hospital now receives a higher income per day from plan payments; number of Blue Cross patients who, because of their contract coverage, go into private instead of semiprivate rooms, thus increasing the hospital's income per day from the patient.

Although the hospital must expect to receive the same net cash income per day from Blue Cross patients whose type of accommodation has not been elevated by plan coverage, full consideration must be given to the hospital's markedly improved over-all income status (when 40 to 75 per cent of population will be covered by the plan) by substantial reduction in the percentage of free cases and by upgrading of income-producing accommodations selected by Blue Cross patients. The hospitals must also consider the downward trend of credit and collection costs per patient day as an ever-increasing percentage of the population becomes covered by Blue Cross.

Today's Cycle Abnormal

Hospitals must not be lulled into a false sense of security by today's abnormal economic cycle. They should take a careful look back to their often precarious financial position as a result of charity loads in the 1930-40 period. They will do well to look ahead and realize what a high percentage of coverage of the population by Blue Cross will mean.

Hospitals and Blue Cross plans are peculiarly interdependent. Plans cannot exist without hospitals, hospitals will need the plans badly in normal times and, even more so, in times of subnormal economic levels.

The general public will demand, and must have, efficiently managed and financially sound hospitals and Blue Cross plans. Hospitals and plans are partners in the vital jobs of providing hospital care to our citizens and of providing a painless way to pay for this care. Certainly each partner has the right and privilege of complete financial, vital and actuarial data from the other.

It seems to me that a proposal to pay hospitals 97 per cent of billings or 110 per cent of cost, whichever is lower, is fair and sound if, and only if, an agreement is reached between plans and hospitals as to precisely what items are to be considered as cost. Will depreciation on equipment, furniture, fixtures and scientific apparatus be included as "operating costs"? Will depreciation on buildings and interest on borrowed money be included? A hospital administrator would hardly want to sign a contract until he knew exactly what is meant by 110 per cent of "cost."

Furthermore, he would want some fairly accurate estimates based on past experience as to whether or not the plan could afford to pay each hospital the rate it would be entitled to under the 97 per cent of billings for the type of accommodations occupied or 110 per cent of average cost per patient day.

Adhere to Official Definitions

Contracts should not define semiprivate accommodations as exclusively two bed rooms. The A.H.A. accounting manual says on page 63: "Semiprivate rooms are those containing accommodations for at least two but not more than four inpatients." Contracts should adhere to this official definition.

If hospitals feel that Blue Cross plans impose on them an added burden of accounting and reporting, let them think of the red tape and delays that would be incident to doing the same amount of business with the federal and state governments.

Because of real or fancied mistakes and misunderstandings, Blue Cross plans must not fail. If voluntary groups cannot compose their differences and mutually agree on ways and means to guarantee hospital care to all who need it, then let's turn the job over to the federal and state governments and take the consequences of our own shortsightedness.

We Don't Need Priorities—but

GLENN R. STUDEBAKER

Formerly, Chief, Hospital Section
War Production Board, Washington, D. C.

THE surrender of Japan has made priority assistance generally unnecessary and Army cutbacks are gradually filling the pipelines of normal trade channels. The War Production Board, however, realizes that during the reconversion period the situation will be spotty as to the supply of goods and there may be cases of real emergency in which assistance is needed.

To provide for such cases a system of MM and CC ratings has been set up. The MM ratings, which are exclusively military, will be used to take care of the continuing military needs, and while they carry a greater priority than do the CC ratings, it is expected that they will be used so sparingly that little conflict will result.

Hospitals should obtain copies of the recently issued orders PR-28 and 29 from their local W.P.B. offices and give them thorough study. All deliveries and ratings under the Controlled Materials Plan were invalidated on September 30, with the exception of textile orders.

Applications for the CC ratings are to be made on Form WPB-541-A and are to be filed with the nearest W.P.B. field office. The field office may rate or deny an application for an item costing $5000 or more, or for a group of items that does not total more than $25,000, and of which no single item is over the $5000 limit. Applications above these ceilings will be forwarded by the field office to Washington for final action.

Applications that would concern hospitals and hospital projects above these ceilings would still be handled by the W.P.B.

Before applying for a CC rating the hospital should make every effort possible to obtain delivery on a nonrated basis. The CC rating is only to be used where definite emergency exists. Question 12 in the Form WPB-541-A requires that a strong justification be set forth in accordance with the criteria.

Question 13 states: "Name at least two suppliers contacted in efforts to obtain each of the requested items. You must show the reasons given by each supplier for unsatisfactory delivery date."

The criteria used in determining the issuance of CC ratings are as follows:

1. The item must be essential to eliminate hazard to life, health or safety of a large number of people and to maintain essential public or other community service.
2. The item must be needed in an emergency to eliminate an actual or imminent breakdown or to replace an item that has been destroyed by flood, fire, tornado, riot or act of God.
3. The item must be needed when, for other reasons, failure to obtain delivery would result in unreasonable and exceptional hardship.

CC Ratings Not Extendable

Generally, CC ratings are nonextendable. For example, a supplier cannot use them to get production materials needed to make the items sold to his customers or to replace in inventory materials used in manufacturing the item. However, a distributor, warehouseman, retailer or other person who resells the item without further application may extend the CC rating when he does not have the item in inventory; he may not extend it to replace the item.

Service equipment for hospitals, such as laundry equipment, kitchen equipment, elevators and pumps, is no longer under control and may be purchased in the open market. Controls are still in effect on delivery of domestic refrigerators. This control will be maintained only until such time as production will meet the consumers' demands.

Doubtless, many difficulties will be experienced by hospitals in meeting their supply needs during this transition period and the Government Bureau of W.P.B. will continue to fulfill its responsibility to the government agencies and to public and private institutions under the new system.

Future Home of Fifty Students

JOSEPH C. GODDEYNE
Architect
Bay City, Mich.

THIS contemplated plan for a nurses' home will accommodate 20 first year student nurses in double rooms and provides 30 single rooms for second and third year students on the second and third floors. In addition, there are three single rooms on the first floor and one on each upper floor assigned to supervisory nurses or technicians. The building, therefore, accommodates 50 student nurses and five others.

The main entrance of the nurses' home is on an axis with the hospital and a tunnel connects the two buildings. This tunnel permits students to pass to the hospital without donning wraps during cold or inclement weather; food is transported from the hospital kitchen and trucks carry the linen directly from the hospital laundry to the nurses' home. Steam, water and electricity are conveyed to the home from central sources in the hospital, reducing the costs of these utility services and centralizing maintenance. The steam and water pipes and electric services are suspended on the walls of the connecting tunnel.

Directly opposite the main entrance of the home on the first floor is the main school office (21) with an open counter so that all points of entrance can be closely supervised. Adjoining this office is a private office for consultation, reception of mail, packages and telephone calls.

Connected with the private office, to the left, is a bedroom for the night supervisor (1).

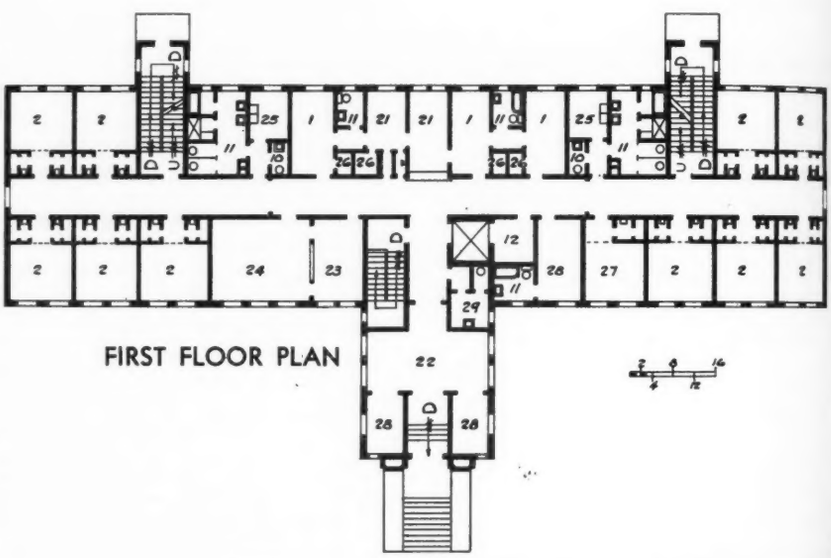
To the right of the main school office is a suite of two bedrooms with connecting bath. Note that all supervisors' bedrooms have commodious closets (26).

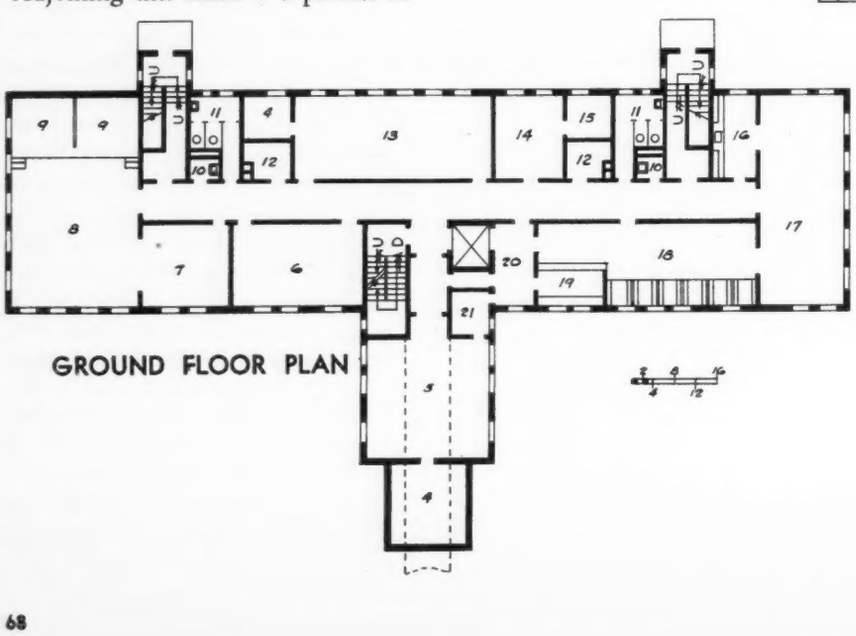
First year students' rooms (2) are made double to give these girls companionship. It is proposed that these rooms shall be equipped with a lavatory and built-in wardrobe for each student.

The area of the rooms, exclusive of lavatory and wardrobe space, approximately 11 by 11 feet, permits the placing of beds with the head against the closet wall and study desks at windows, or reversal of these positions in summer time. If it is preferred, room partitions are wide enough to accommodate the beds in twin-bed fashion with desks at the opposite wall, thus providing three satisfactory arrangements. Above the lavatory alcoves and wardrobes, ceilings are furred to approximately 7 feet.

Toilet facilities are provided on the basis of one toilet to five students, and a tub and shower (each separately entered) serves 14 students.

In connection with other necessary plumbing facilities, two small laundries (25) on each floor, containing a two-part laundry tub, drying facilities and ironing board, permit each girl to wash her lingerie, hose and other personal things that are not usually "sent out." The close proximity of these individual laundries makes a large central laundry unnecessary and permits each girl to hang her washing in her own "yard."





Architect's rendering of the proposed nurses' home.

Soiled linen chutes, one for wet and one for dry materials, drop to the linen room (12) on the ground floor from which linen is trucked to the main laundry.

A janitor's closet (10) with service sink, dust mop cleaner and waste disposal completes the ensemble—a compact utility unit—in stack with similar facilities on each floor.

The library (24) and study (23) are separated by a glazed partition and are entered from the public part of the main floor corridor. They can be used for group meetings that are too large to be accommodated in any of the offices.

Room 28 may be used for special guests or a family visit and room 27 may house the occasional mother who is unable to find hotel accommodations, or it may be pressed into service for two additional first year students.

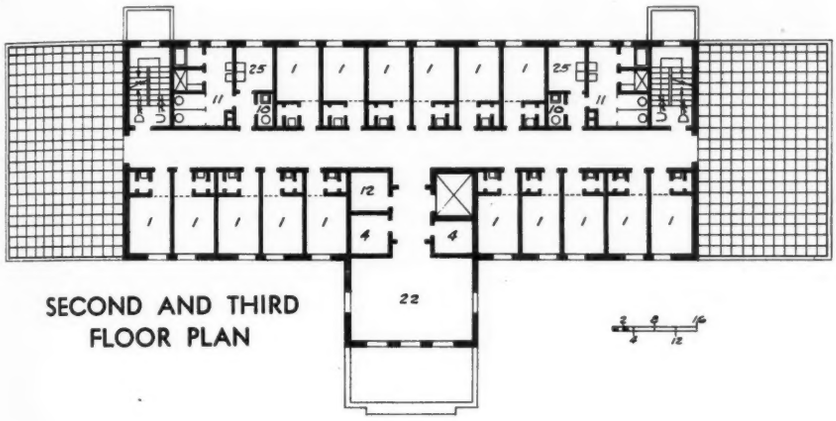
Main corridors are 7 feet wide. Since the structure is wall bearing, this extra width in the corridors is particularly advantageous for strength; also it helps to care for traffic on the ground floor.

The ground floor, which is about 3 feet below grade, houses not only classrooms and laboratories but also a common recreation room (17) and cafeteria (18).

The dietetics laboratory (5) is planned with direct communication with the receiving and dishwashing room (20) where food from the main hospital kitchen is delivered. The vestibule to the dietetics laboratory assists in confining the odor of food. The dimensions of the dietetics room are approximately 22 by 23 feet, to care for 16 students at eight individual tables, or about 30 square feet per pupil.

The storage room (4) will be located in space available under main entrance steps. A small office, 7 by 8 feet approximately, permits supervision of food preparation in the cafeteria and in the dietetics room.

Rooms 18, 19 and 20 comprise the cafeteria unit. Hot food is transported from the hospital kitchen

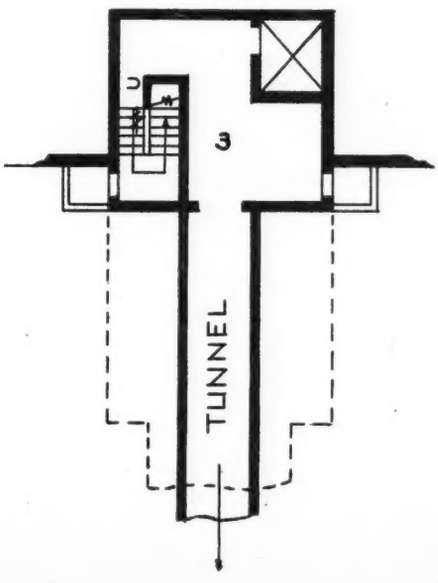


SECOND AND THIRD FLOOR PLAN

KEY TO FLOOR PLANS

1—Single bedroom
2—Double bedroom
3—Vestibule to tunnel
4—Storage room
5—Dietetics laboratory
6—Classroom
7—Model bedroom
8—Demonstration and lecture room
9—Model room
10—Janitor's closet
11—Toilet
12—Linen
13—Chemistry and microbiology
14—Trunks and storage
15—Lockers
16—Kitchenette
17—Recreation room
18—Cafeteria
19—Serving
20—Receiving and dishwashing room
21—Office
22—Lounge
23—Study
24—Library
25—Laundry
26—Closet
27—Guest room
28—Visitors
29—Men's toilet

TUNNEL PLAN



through the connecting tunnel and up by elevator to room 20. Food is then placed in a steam table in the counter of room 19 for self-service. Booths, each seating four upper class nurses, are suggested and the rest of the nurses will sit at tables.

The cafeteria connects directly with the recreation room (17). Furnished with lounge chairs, davenports and reading tables and lighted from three sides, this recreation room will be restful and inviting.

The kitchenette (16) is sufficiently commodious for two grilles, a small refrigerator, sink and cupboards so that small groups can prepare refreshments.

The classroom (6) is 15 by 24 feet approximately, large enough to seat 30 students, allowing 12 square feet of space for each. A large sized slate blackboard, with chalk trough and corkboard panel at top, is planned for the front wall; side and rear walls are to have corkboard only for tacking up illustrative work, bulletins and instructions.

The model bedroom (7) can be separated from the demonstration and lecture room (8) by a folding partition. In this 15 by 16 foot bedroom complete furnishings for a private room will be set up or a semi-private room may be simulated. Chairs can be arranged so that students can view methods and routines taught with the aid of dolls or actual human subjects.

The clear seating space in the demonstration room (8) is 24 by 28 feet, large enough for 50 tablet arm chairs. This demonstration room can also be used for any meetings at which an especially large number will assemble.

The partition between rooms, number 9, is removable and serves as a blackboard for teaching when turned toward the audience. Each alcove (9) is approximately 11 by 11 feet.

Here, members of the teaching staff show how modern intravenous injections are given: saline, glucose or blood plasma, or an actual blood transfusion. Note that these alcoves are on an elevated platform about 2 feet above the floor.

The microbiology laboratory (13) will be equipped with four tables accommodating four students each. The approximate dimensions of the room are 15 by 37 feet and blackboard and corkboard will be erected on interior walls. All tables will be supplied with water and drainage, gas, air and electrical outlets. Shelves in the storage room (4) will house special equipment and bulk chemicals.

In the trunk storage room (14) three deck shelves for trunks will be erected and shelves and lockers for small packages are proposed in the locker room (15).

The plan provides an abundance of light and ventilation. The second and third floor lounges (22) are centrally placed with an excellent view of the grounds. The tiled terraces at each end of the second floor can be built up, thereby adding 12 rooms at each level, or 24 extra single rooms for both floors.

This Idea Holds Water

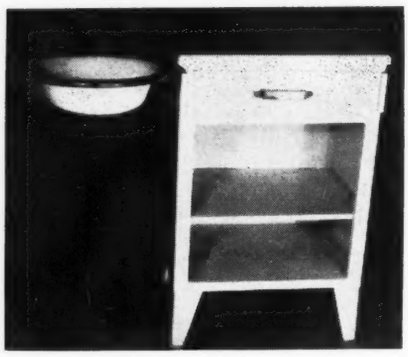
FRANK L. JENNINGS, M.D.
Sunnyside Sanatorium, Indianapolis, Ind.

IN EVERY hospital, ingenuity was taxed during the war to meet shortages in labor and equipment. At Sunnyside Sanatorium, Indianapolis, one of our problems was that of enabling the patient to keep his hands and face clean throughout the day. This was finally solved by providing him with a wash basin of water at his bedside at all times.

The labor shortage became progressively worse until we reached a point at which the patient received wash basins only twice daily—early in the morning and in mid-afternoon. It was obvious that better washing facilities were necessary and we reasoned that no more labor would be involved if the basin could be kept by the bedside and replenished with water three or four times daily than was involved in carrying it back to the utility room to be cleaned twice a day.

Basins of water could not be placed on top of the bedside cabinet because in a tuberculosis hospital, such as this, where four fifths of the patients are confined strictly to bed and their bedside cabinets are filled with many personal articles, the top of the cabinet is considered much too valuable space to be encumbered with a wash basin all day.

We had seen a bedside cabinet which had a ring holder for a wash basin, so located that the ring and basin could be swung into the table out of sight. The idea appealed to us, but knowing how full of personal things the lower section of our patients' cabinets always was, we did not feel that such an arrangement would be practical.



We feared that the water, while out of sight, might be spilled, thus damaging the personal effects. We therefore hit upon the idea of fastening a ring for the wash basin on the corner of the bedside cabinet. Inquiries to the various hospital supply concerns failed to reveal a unit of this type and with the factories busy on war material, none was interested in helping us solve our problem.

About eighteen months ago we appealed to the authorities at the Indiana State Prison, who were not confronted with the labor problem of the commercial manufacturers, and from the prison we obtained not only the ring and the attachment to fit on the cabinet but also a large number of complete cabinets (see accompanying cut). These units have been in operation now for some time and we have been able to supply our patients with frequent changes of water and, at the same time, they have had water at their bedsides throughout the day.

Thus, during the war, when industry was confronted with a multiplicity of orders and a severe labor problem, when commercial bedside cabinets were scarce and when this hospital, too, was confronted with labor difficulties, a solution was found to a perplexing problem.

Los Angeles Organized

For Better Convalescent Care

HARRY HYMAN
Superintendent
BERNICE HARRIS
Public Relations Counsel
Rest Haven, Broomall, Pa.

A MAN singing alone from the stage of a vast auditorium cannot be sure his voice is heard by all of those present, but when his voice is joined by hundreds of others, it carries to the farthest reaches of the hall. If I may extend this metaphor a bit, I may say that the plight of the lonely minstrel is no different from that of the convalescent home today. For it, too, stands quite alone in the center of a vast army of people, unable to make its presence felt as it should be felt, not quite sure of where it belongs in the scheme of things or whether it belongs at all.

More and More Will Need Care

That it most certainly does belong and that the need for it is growing progressively greater are facts with which anyone who is at all familiar with the situation will agree. If we will only remember that, besides those who would normally require convalescent care, many of our returning service men and women will be in need of a period of rest and recuperation from the terrors of war, we shall quickly see that this is certainly the time for intelligent planning and acting on the part of convalescent home administrators and operators.

Readers who recall the article, "Convalescent Home: the Bridge Between Hospital and Health," in the August issue of The Modern Hospital, will remember that mention was made of an organization "among the superintendents of these homes, where problems of administration and care could be discussed, and experiences and ideas exchanged for the benefit of all." Such a plan is not a dream but is actually in operation—and highly successful operation—in Los Angeles. Because I believe that the plan may aid other communities in setting up a similar organization, I should like to go into some detail on its operation.

The nucleus of this organization is a convalescent home registry, conducted by the founder, James Geddes, and his staff. This registry lists the names of 150 licensed establishments in the city, all of which have met the standards set by the registry. All information useful to the prospective patient and to the homes is compiled: type of home, type of case desired, price range of the home, accommodations available, accessibility of the home and vicinity in which it is located.

With this as background, let us see how the registry operates. A prospective patient or, more likely, a member of his family telephones the registry, giving relevant particulars about the patient, his diagnosis, case history, habits and previous care, vicinity in which placement is desired, ability to pay, type of care wanted and date when accommodations will be needed.

The registry then checks its records, confirms vacancies and is able to provide names and addresses of those rest homes suited to the case in question. Free motor service is maintained for those who wish to visit the suggested homes before making a decision.

The registry staff writes and publishes a monthly newspaper which is distributed to its members. I shall say more about this a little later.

Now let's see what is achieved in this way. First, and I believe foremost, is the fact that the plan discourages the operation of unlicensed, undesirable "outlaw" homes. Competition here, as in other fields, plays its part. The home that cannot or will not live up to the standards set by the registry soon finds that it is losing business; it must either improve or suffer the eventual risk of closing entirely.

The plan therefore performs a twofold job: in decreasing the number and power of undesirable convalescent homes it strengthens the position of the worthy, honestly-run home, and, in so doing, it heightens the prestige and dignity of the entire profession.

The aspect of the registry that is most likely to win the immediate approval of convalescent home operators is its ability to bring the right patient and the right home together. How often has dissatisfaction been caused by placing a convalescent patient of a particular type in a home which does not specialize in, and is not prepared to cater to, that kind of case!

With all of the facts available regarding both the patient and the home, much of this unpleasantness can be avoided. Members of the hospital and medical professions can now give a satisfactory answer to patients who ask, "Where can I go?" "Where will I be happy?"

Paper Keeps Them in Touch

It is through its monthly newspaper that the registry helps bring convalescent home directors in touch with one another and aids them in solving common problems. Let us take a recent issue as an example. Here is an editorial entitled "How Much Do You Charge for Care?" from which I quote:

"A basic charge may well be made in some instances but, for the most part, and certainly in our experience, each case has its individual needs, which bring it under the cost for care rather than the cost of board and room. There may be cases which are often described as needing no care, but it does not hold that one enters a rest home or sanitarium needlessly, and the presence of a nurse, being one of the patient's requests, is indicative of need for care. And it most certainly follows that the degree of care required, or the type of diet necessary, is a determining factor in the cost or rate structure.

"Every precaution must be taken to prevent such standardization as might freeze rates at a figure which would permit of minimum care.

Leave this to rooming houses. Each rate quoted should be flexible enough to admit of some unforeseen development, such as incontinency, rarely admitted, but often present in aged cases, and which is a costly feature in personnel and linen.

"The time element as it relates to the proposed time of occupancy, that is, one week, two weeks or a month, has its bearing, as most of the costs of the small sanitarium are figured on a monthly basis. The short-time case has not proved popular with sanitariums of the smaller type, which are not staffed to extend maximum care for minimum case life. The cost of such short-time cases must be more in proportion to the long-time occupancy and care."

Here is another sample, called "Do It Legally."

"Whether you are just starting a business or enlarging your present facilities by converting singles to doubles, with or without structural changes, the safe way is to obtain permission of the necessary authorities. The care and housing of the ill and aged concern the departments of planning, fire, health and building in both city and county government, and the careful operator maintains close contact with these agencies.

"The cost of licenses and permits, that is, the financial cost, is very small, but the cost of bringing the building into compliance with the requirements of the law, before such licenses or permits may be granted, oftentimes is such as to make the whole venture costly beyond a profitable operation. These agencies stand ready to serve you and welcome your inquiry—in fact, urge it; otherwise they may have to order the correction of such changes as have been made without their approval.

"In considering new locations it is well to bear in mind the fact that postwar requirements for sanitariums will be very strict, and the building chosen for your use during the war period may not be in compliance with these rigid postwar conditions. No operation can be termed legal unless it has complied with regulations covering such business and has such licenses or permits as may be required."

Such suggestions present new sidelights on various issues to the experienced operator and can be of inestimable value to the person or society just setting up shop.

It Binds Readers Together

In addition to its practical, helpful news, the paper contains brief items on the activities of its subscribers and questions and answers on convalescent home operation. All in all, it binds its readers together, giving them the strength of numbers and the comfort of common knowledge.

The registry also assists homes in setting up bookkeeping systems, making out Social Security returns and similar tasks. It has proved so successful that it has been endorsed by the chamber of commerce and used by the Los Angeles County Medical Association.

This is the sort of organization that acts for the good of everyone concerned, guests, administrators and families of guests. And, in a most positive fashion, it raises the standards of the profession it represents, gives to it a needed feeling of security and dignity and helps to inspire the community with confidence in that profession.

VOLUNTEER ACTIVITIES

Service Is Centralized

In St. Louis all volunteer hospital aides are recruited, trained and referred through the Central Volunteer Bureau of which Frances Goodall is secretary. Since Pearl Harbor this bureau has placed almost 3600 volunteers in St. Louis hospitals. At the present time the bureau has 1200 volunteer aides in 18 hospitals.

Far from slackening the pace, the bureau, during the fourth year of war, trained and placed 945 women and junior hospital aides and 89 men aides. Training courses for the men were given at Deaconess, Barnes, City and Jewish hospitals. Women and juniors took courses at St. John's, Missouri Baptist, Barnes, St. Mary's and De Paul, and Washington University School of Nursing.

In addition to hospital aides the Volunteer Bureau last year trained and placed 42 clinic aides in 12 clinics, 163 child care aides in 24 child care centers and various case work aides, recreation leaders, clerical aides, occupational therapy aides and motor corps drivers. These groups represent an 18 per cent increase in enrollments over the previous year.

During the year also 228 volunteers received distinguished service awards for hours of service ranging from 500 to 6000.

Gift Shop Idea Is Catching

Latest recruit to the gift shop idea is the auxiliary of Norwegian-American Hospital, Chicago. R. C. Williams, an interior designer whose wife is an auxiliary member, has completed the plans for the shop, which will open this fall. Mr. Williams advised the auxiliary when it redecorated and refurnished the expectant fathers' room as a Father's Day gesture in 1944.

The Norwegian-American auxiliary is only five years old but its financial and moral support to the hospital has been telling. One of its favorite tasks is the upkeep of the roof garden for the patients' enjoyment. Mrs. R. H. Warden is serving her third term as president of the auxiliary.

Four and Twenty Juniors

They have returned to school now but they are not forgotten, those 24 smiling junior aides that dashed about Queen's Hospital, Honolulu, T. H., all summer, their blue and white print uniforms, as well as their youth, identifying them.

Before they started work, they had twelve hours of intensive instruction in addition to lectures on hospital etiquette and complete orientation, the latter to fit them for running errands.

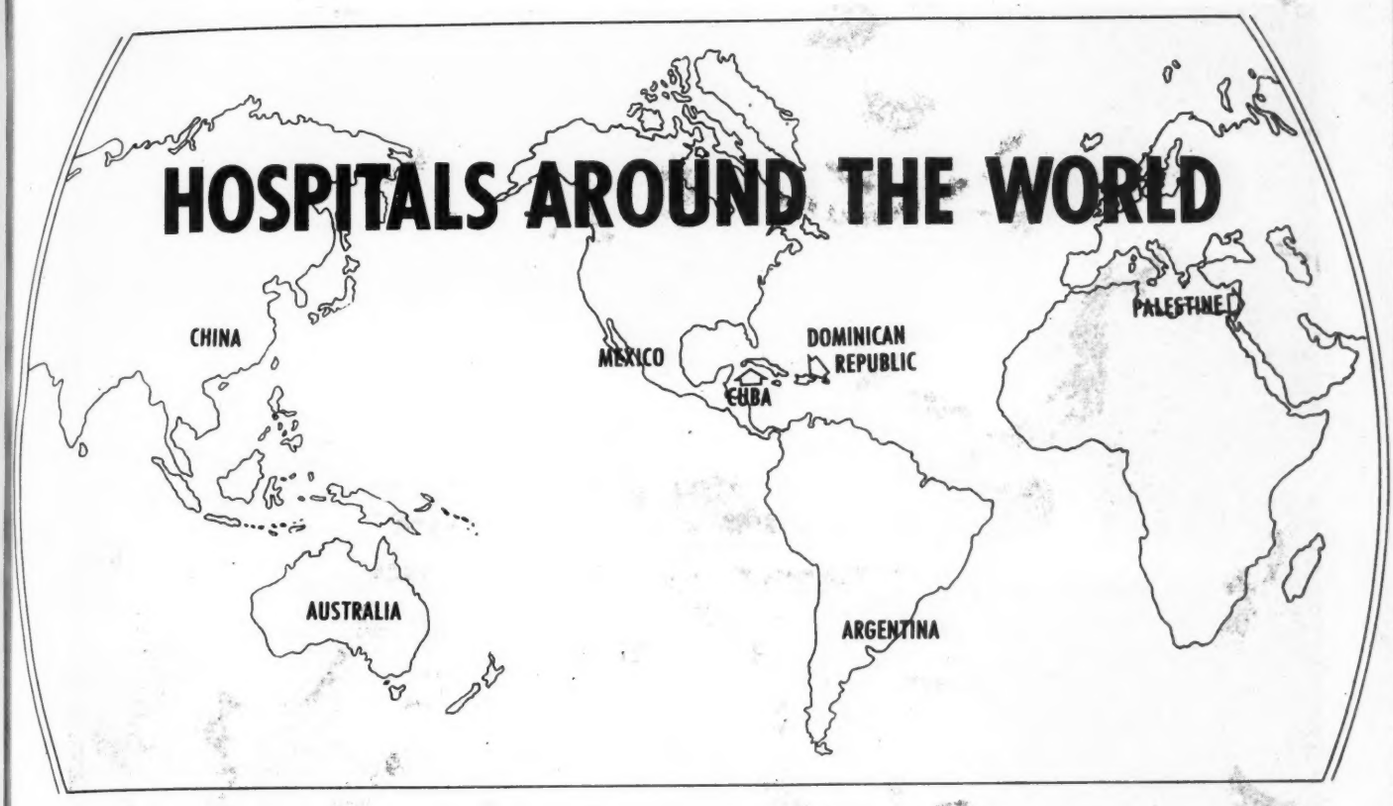
The junior aides were far more than errand girls, however. These were some of their tasks: operating wheel chairs; helping to discharge patients; care of the unit after the patient was discharged; general housekeeping; care of linens; preparation of patients for meals and assistance in feeding the helpless; bedmaking; nourishment service.

To encourage them in their efforts some inducements were offered. At the end of their first hundred hours, they received an automatic pencil; for the second hundred hours, they were given a matching pen.

Another device to keep junior aides interested is the practice begun by New Haven Hospital, New Haven, Conn., of holding periodic Mother and Daughter parties. At these parties, service awards are given to juniors and new members are welcomed.

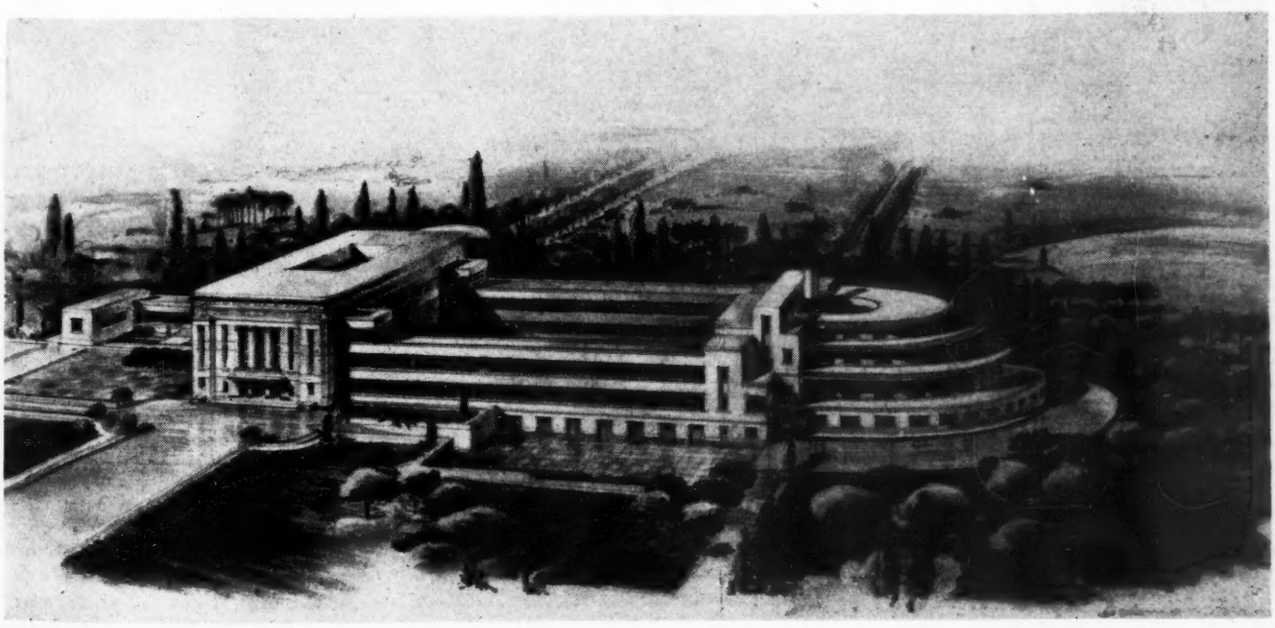
Lectures for Volunteers

The Chicago Council of Directors of Hospital Volunteers began a short course of lectures on hospitals, public health and selected medical topics this autumn. These evening lectures are open to all hospital volunteer workers.

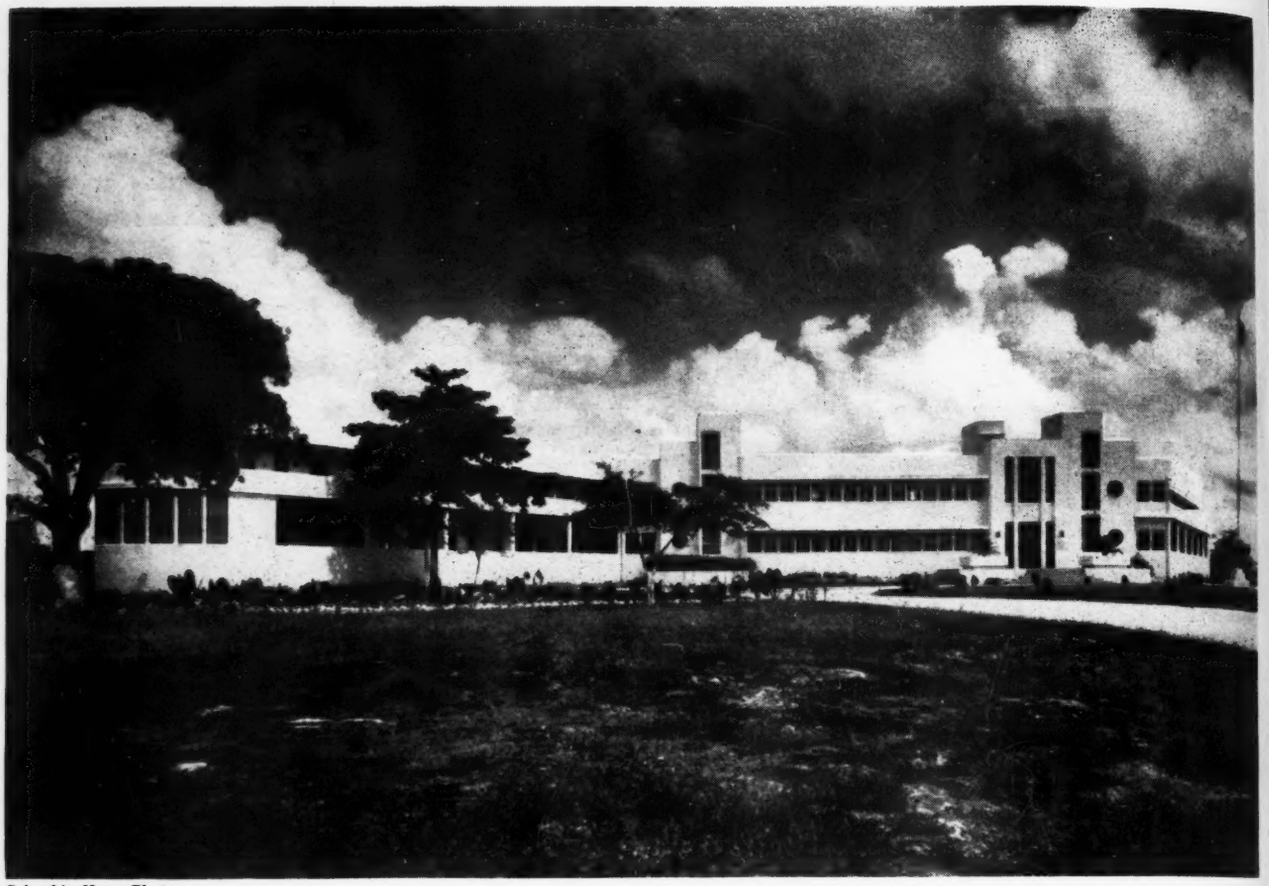


Seven examples of hospital architecture to meet varying needs

CUBA: The Hospital for Tuberculous Children was constructed in 1940 on the outskirts of Havana. Luis G. Dauval, the architect, has made extensive use of balconies, reminiscent of the decks of a ship, to achieve the maximum of light and air. Each three bed room is provided with a lavatory, two bedside tables, a study table and two chairs and shares a toilet and bath with the next room. The wards measure approximately 11 by 14 feet. A service corridor flanks the rooms on one side and on the other is a glazed corridor that serves the small patients as a sun room.



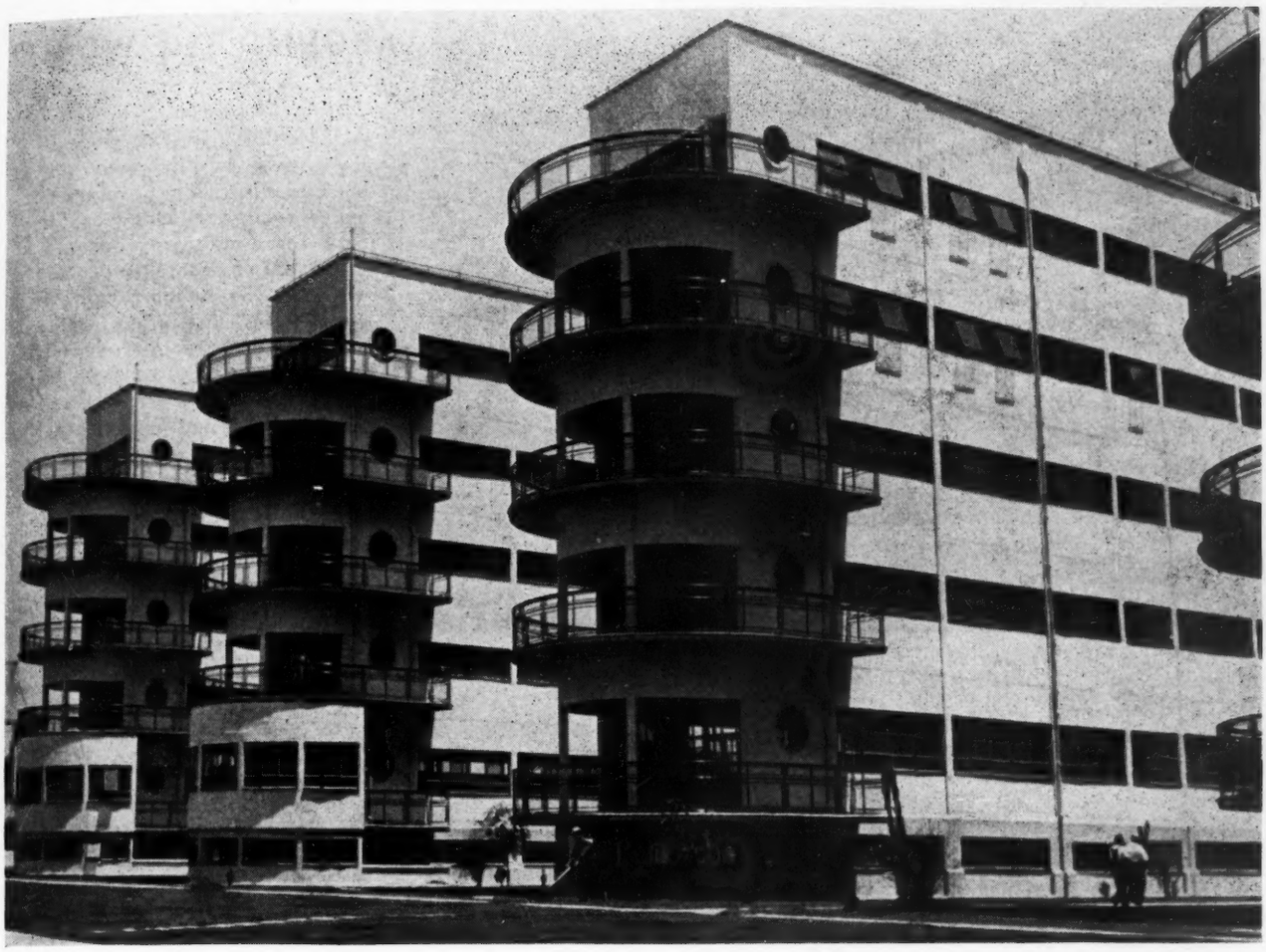
HOSPITALS AROUND THE WORLD



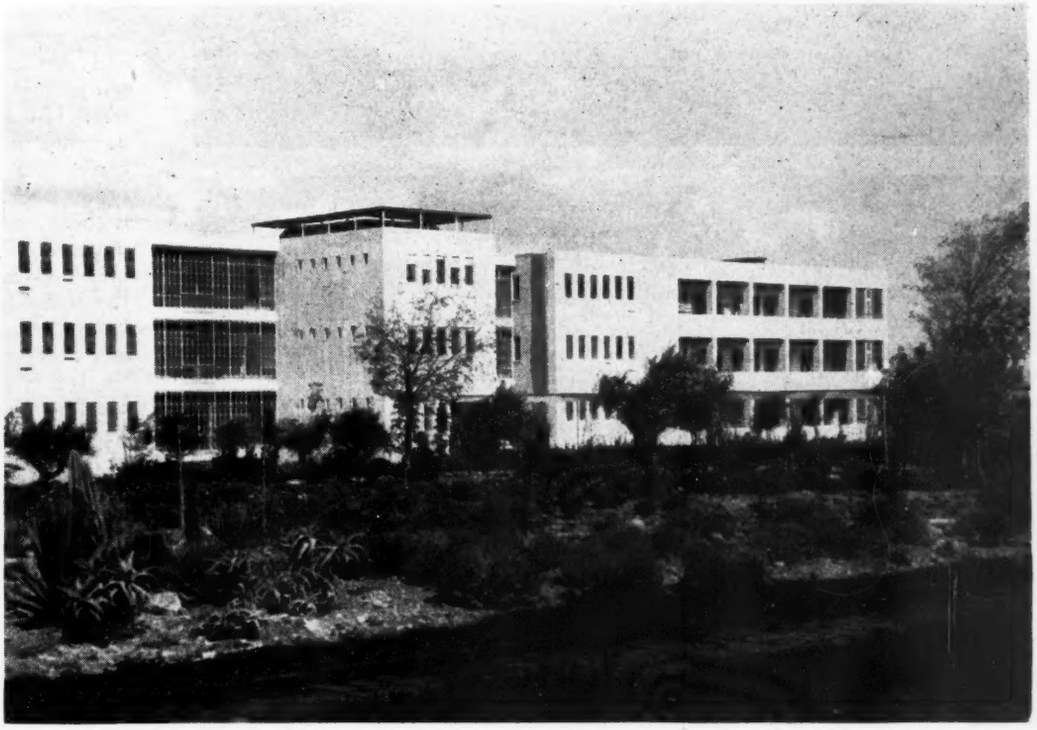
Columbia News Photo

DOMINICAN REPUBLIC: The "Hospital Sanatorio Doctor Martos" for tuberculous patients is situated north of the city of Trujillo. It belongs to the Department of Health and Public Welfare of the Dominican government. Built of reenforced concrete, the structure is Z-shaped to obtain the maximum of light and air.

ARGENTINA: British Hospital at Buenos Aires celebrated its centennial in 1944. In 1844 the bed capacity of this institution for British nationals was 20; in 1944 it was 279. Plans for improving and extending the hospital include the erection of a building for tuberculous patients. Photo, the Universal Trade Press Syndicate.



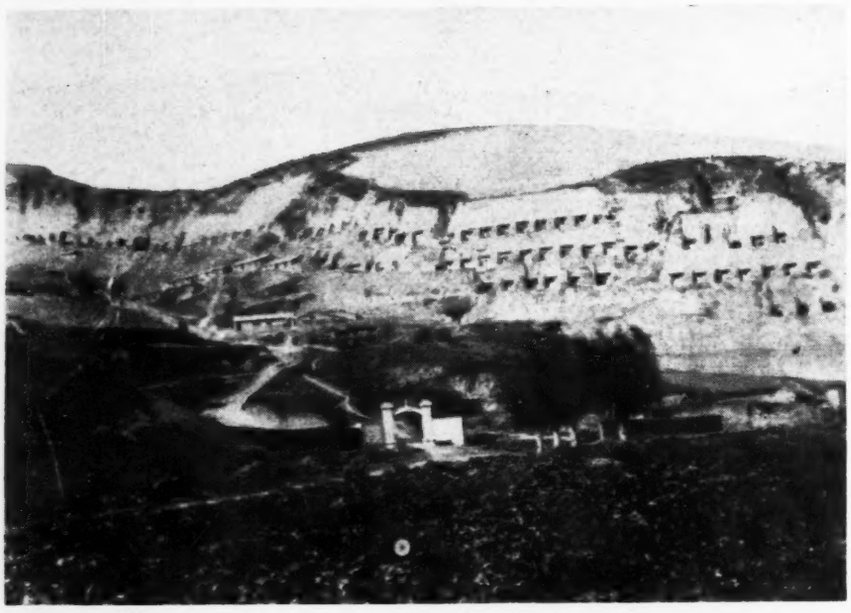
MEXICO: Children's Hospital is the second unit of the medical center in Mexico City. The six story, 550 bed structure will be used as a teaching tool for the medical school of the National University. The wards project outward from the main body of the building, so that direct light and sunshine enter every room.



PALESTINE: Rothschild-Hadassah-University Hospital and Medical School, administered and supported by Hadassah, the women's Zionist organization of America. This photograph shows the newly planted garden atop Mount Scopus, Jerusalem. Hadassah supports a program of public health, hospitalization, child welfare.

HOSPITALS AROUND THE WORLD

AUSTRALIA: This 10 story ultra-modern hospital was built by the Australian government under reciprocal lend-lease to care for American troops recuperating from illness and wounds. The building contains laboratories, operating rooms, nurses' quarters and administrative offices. It has special equipment for the treatment of fevers and other illnesses that the men incurred in jungle fighting. Photo, courtesy of O.W.I.



CHINA: Up in the "guerrilla" country of Northwest China are four International Peace Hospitals, for which the one at Yenan in Shensi Province was the model. The 400 bed hospital was first established in 1938 with 180 beds housed entirely in caves. In 1940 it was reorganized as the rear base of the International Peace Hospital network and was named in memory of Dr. Norman Bethune. The hospital is organized into three sections: (1) main medical and surgical section with 250 beds; (2) convalescent home with 100 beds, and (3) outpatient department with six clinics and an emergency ward of 50 beds. The surgical wing is shown at the bottom of the page and the center photograph gives a general view of the "hospital built in the hills." Complications from old wounds and acute or difficult cases are treated in the medical and surgical section. Graduates of Yenan Medical University serve as medical assistants in the hospital and the nurses are trained by the university or by the Chinese Red Cross Medical Corps. The total number of staff members is 300. Dr. Lu Chi-Chung is superintendent.

Here Is a Preview of New Materials

ALMA H. VALLIN
Construction Unit, Bureau of Foreign and Domestic Commerce

BOTH the quantity and type of building we are to see, once new construction gets under way, will be determined in no small degree by the new and improved materials available at that time.

These materials, of course, in themselves will not bring about any radical change in construction practices or in the outward appearance of most of the structures in which they are incorporated. No miracles are presaged. But the fact that these materials are to be available to supplement and even replace in part older materials seems to indicate that, in general, buildings of tomorrow will be better structures than their predecessors, more comfortable to live and work in, more economical to operate and will last longer.

New Structural Materials

Many buildings that are to come will be constructed with "breathing walls." These consist of an outer or veneer surface of brick backed up with hollow tile of special design which, in turn, is covered with 4 inches of rock wool. Open vertical joints in the outer brick veneer permit air to flow through the flue-like passages in the tile which permits the insulation to "breathe" and thus minimizes the condensation. A "breathing wall" is said to have the insulating value of an 80 inch brick wall, although it is only a fraction as thick.

Other buildings will be constructed of a new clay tile unit finished to simulate face brick. This can be used for a wall which, although only one tile thick, will present a finished appearance both outside and in.

Then there is a precast hollow reenforced concrete slab or beam unit which can be used for either floors or roofs. Light of weight, but rigid and strong, it will speed construction by eliminating the need for forms. Various types of flooring and roofing can be applied to its upper surface while the underside of the units can be painted or otherwise decorated directly without having to be covered with plaster first.

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Treated Woods and Plywood

Much wood will also be used in new construction. It will, however, be a better, more lasting product than it has been. For example, great strides have been made in the impregnation of wood to render it fire-resistant and flameproof.

And then there are plywood panels of large size, reportedly measuring in some instances 8 by 50 feet, which will permit of full-wall construction with joints reduced to a minimum.

Another plywood panel is surfaced with resin-impregnated fiber of the phenol type. The resulting boards, which are hard and smooth, can be worked with ordinary carpenters' tools and can be attached with nails, screws or bolts just as ordinary plywood is. The surface, said to be highly wear-resistant, takes paints, lacquers and other finishes easily.

Plasticized wood also offers many interesting possibilities. It is wood that has been treated with an urea compound until, when heated, it becomes temporarily pliable and can be bent and twisted into a variety of shapes. Cool again, it retains the shape given it while heated. One of the uses foreseen for this material is to make curved stair railings.

Employment of pressure-treated lumber at a series of especially vulnerable points and the use of untreated lumber elsewhere are expected to both minimize structural damage from termites and reduce building costs as compared with structures using only treated lumber.

Adhesives and Aluminum

New adhesives will play an important part in the manufacture of several of the materials just described. One specially prepared cement, which can be brushed on or applied in the form of a tape, permanently bonds metal, wood, plastics, ceramics, fiberboard and rubber in any desired combination upon the application of heat and pressure. Another, a thermoplastic, is said to replace screws and rivets in many applications. A third—this time an improved casein glue—is designed for use where moisture and heat are extreme.

Aluminum, expected to be available at prices lower than ever before, will find many new applications in construction. Its proponents advocate it for flashing, guttering and spouting and in replacing trim of other metals. Wall panels of aluminum, as well as whole bathroom and kitchen units, are also proposed.

Other interesting materials in this field include a new vitreous enamel in white and colors which can be applied directly to an alloy steel without the prior application of a base or ground coat. The secret seems to be that the steel base should contain some titanium which, it has been discovered, has the property of eliminating pitting, specking and blistering in the enamel coat.

Waterproofings

Several new waterproofing materials have been announced. One, a slow-drying material, is intended to be applied to damp walls, foundations and underground pipe. It is said to be acid and alkali proof, to brush readily and not to become brittle or crack at low temperatures or to ooze or soften in temperatures as high as 125° F.

A copper-fabric through-wall flashing is reported to eliminate seepage. Composed of sheet copper, asphalt and an impregnated fabric, it is readily shaped during installation to follow any contour.

Not a waterproofing, yet serving much the same purpose, is a newly designed vitrified clay "skip-pipe" intended to keep basements dry by

preventing seepage of ground water. A cradle in the top of the pipe collects water which is then discharged into the pipe proper through fixed slots at each joint and other ground water is admitted through a series of lugs in the bell sections. The combination has, it is claimed, greater dewatering capacity and permits faster discharge of collected water than does full-round pipe.

Insulating Materials

Weighing as little as 3 pounds a cubic foot, a new silicon-compound insulating material is reported to be water-repellent. Looking like snow and pouring like water, it is expected to find many applications. Another insulation, said to weigh only one seventh as much as cork, is a plastic foam hitherto used only for war purposes. Buoyant, yet semi-rigid and having good thermal and sound insulating properties, it is expected to find widespread use.

Acoustical Materials

Also reported is an acoustical plaster which, in addition to absorbing sound, is fireproof and intended for application on ceilings and on side walls above the abrasion line. Smooth and fine grained in texture, this plaster comes in six colors and can be used as readily in remodeling as in new construction since it requires no special preparation for its application.

Exposed pipe, as well as wires and cables serving electrical equipment, will be protected by a new plastic tape made of vinylite resin. This tape is flexible, elastic, heat-resistant and flame-resistant and is said to protect whatever it covers from caustic or corrosive fumes, oil, grease, alkalies and moisture.

Floors and Floor Coverings

Some of the most interesting of the new building products fall within the field of floors and floor coverings. One, said to feel like rubber and to wear like stone, is self-bonding and can be laid over old concrete, wood or composition floors without the use of additional adhesives. Furthermore, this new floor material is described as self-healing, that is, small holes or cuts made in it disappear in time.

Still another flooring material was developed to meet the needs of the U. S. Navy for a plastic covering for use in shower and locker rooms and in swimming pools. Besides being nonconductive and resistant to soil, grease, fire and shock, this material contains germ-destroying agents to prevent the spread of such infections as athlete's foot.

One nonslip plastic floor coating, which can be used over old floors of almost any kind, can be applied after a building closes for the night; it becomes hard enough to walk on by morning.

Where explosions constitute hazards, a flooring of a new, nonsparking material will be available to the postwar builder. This material was originally developed to minimize the danger of explosions caused by static electricity in arsenals and powder plants. It is said to be less expensive than flooring made wholly or in part of copper, copper wire or rubber.

An entirely different type of flooring requires only the addition of water and cement to produce a surfacing material reported to possess approximately four times the compressive and tensile strength of ordinary cement-topped floors. This material is especially recommended for use where traffic will be heavy or where resistance to water, oil or other spillage is required.

There is a new acidproof brick floor which has been developed and which resists the destructive action of chemicals and organic substances and also holds up under heavy traffic. Since it may readily be flushed clean, it is especially recommended for use in hospitals, dormitories, cafeterias and similar establishments.

Finally, there is a flooring that is basically similar to synthetic rubber. Heretofore limited to war uses, it is scheduled to be made available to modern builders in two forms—as tile and as latex—which may be poured over a subfloor and then troweled smooth. Its manufacturers suggest that in the latter form it can, by the addition of marble chips, be used to simulate terrazzo.

New Paints and Lacquers

Announcements have been made of several new paints and lacquers which will ultimately become available. One of the most promising of these, an infra-red paint, was originally developed for use in camouflage work. Because it possesses unusually high heat-reflecting properties, it is expected to be used on radiators to increase their efficiency, on oil, gas and gasoline storage tanks to reduce evaporation and on refrigerator cars and cold-storage warehouses to cut down heat absorption. The cost of operating these facilities is expected to be reduced by use of this paint.

A new resinous surface coating, made from sugars and starches recovered from farm crops, has many of the qualities of varnish plus the ability to withstand high temperatures and the action of many chemicals and solvents.

New ready-mixed paints, of which there are several, feature heavy consistency and are designed not only to cover surfaces adequately with a single coat but also to seal cracks and leaking joints.

Then there is a metal-base solution especially developed to surface-coat any materials comprised of cellulose fibers, such as wood, certain fabrics and rope, and to protect them from rotting and from the attacks of fungi and insects. Remarkably enough, it has no offensive odor.

Heating and Air Conditioning

Experimental models of new coal-burning furnaces and room heaters promise greater comfort and much lower fuel consumption. All of them feature controlled and usually high speed combustion. Oil-burning and gas-burning furnaces and room heaters will also feature high efficiency and low fuel use.

Offices and single rooms generally can be cooled by air conditioners of the wall type which will, it is claimed, remove up to 90 per cent of the latent heat present. Furthermore, they will do this without causing the cold, damp feeling so frequently encountered. Instead, it is said, this new unit will produce dry, healthful and comfortably cool air.

Windows and Doors

Windows that close themselves when it rains will be installed in many buildings of the future. A few drops of rain falling onto a moisture-sensitive switch will set in motion a mechanism patterned after devices used today to raise and lower the landing gear on aircraft. Another type of window will open or close as the temperature rises and falls.

Simple in construction, as well as weatherproof, a ventilating unit designed for installation in walls or

panels of glass blocks can be left open during rain.

Also available to modern builders will be lightweight garage doors made of an aluminum alloy developed for use in aircraft. A special counterbalancing feature facilitates installation and does away with tracks, counterweights and springs.

New Electric Devices

Among the war-time developments scheduled to be carried over into peace-time building is a system of electric wiring, the capacity of which can be varied to correspond to the load it must carry. Employing tubular copper conductors enclosed in molded plastic, it is comprised of interchangeable interlocking sections designed to be attached to walls or ceilings as may be required.

Other wiring will be covered with a special thermoplastic insulation which is characterized by low moisture absorption. Additional features claimed for this insulation include resistance to oils, acids, alkalies and flame.

Plaster, concrete and paint in the buildings of tomorrow will be dried uniformly and rapidly through the use of small, portable infra-red heat units. Danger of freezing plaster will also be a thing of the past in buildings where these units are employed.

A new 30-watt ultraviolet arc lamp soon to be available for installation in schools and hospitals is reported capable of killing 90 per cent of all disease-producing germs in 700 cubic feet of air in one minute. Installed in a room measuring 10 by 10 by 20 feet, it will, according to its manufacturer, disinfect all of the air in the room once every 10 minutes. A smaller 8-watt arc will disinfect 100 gallons of water an hour.

Still another method of sterilizing air employs a gaseous discharge lamp of the cold cathode type to radiate ultraviolet rays.

Miscellaneous

In the buildings that are to come, switches will be more easily located by newly invented luminous switch plate covers. Inconspicuous by day, they will glow in the dark after exposure to either day or electric light.

Assembling ducts and other sheet metal work will be facilitated by a recently devised connector strip which is claimed to possess the further advantage that it may be removed as readily as it is applied and without injury either to the strip or to the materials joined.

Improved porcelain-on-steel partitions for use in washrooms and designed to be hung from the ceiling will be available for installation in hospitals and elsewhere. The flint-hard, glasslike surface is described as impervious to odors, acids and moisture.

Thus, it may be seen that a wide variety of new and improved materials is to become available to the builder now that the war is over. Even if adequate supplies of these materials should soon be at hand, their exclusive use is not to be expected, however, since established practices in utilization of familiar materials are not easily displaced. But indications are that the building trades will gradually assimilate many of these products and materials if they are to live up to the reputation established by their specialized war-time rôles.

Research in Psychiatry

GROSVENOR B. PEARSON, M.D.

Director, Western State Psychiatric Institute and Clinic, Pittsburgh

REGARDLESS of other definitions, we think of research ordinarily as the intensive and concerted effort of a specially trained worker to explain a phenomenon in a logical scientific way. Possibly the phenomenon was first described by the clinician; or it may have been a development of other research methods. At any event the researcher attempts to control his observations so as to establish a fact. We think of the work as being carried on by a brilliant thinker, aided by all the paraphernalia of his trade, with the help of extensive libraries, laboratories and willing workers. This is the common, naïve concept of "pure" research.

There is much to be added, though. The physician gathering material on the ward is also engaged in a type of research. So is the painter interested in the practical aspects of his work: will a new paint stand up under adverse conditions of use and climate? So, too, is the housekeeper concerned with the effects of a new cleaning agent: not only will the detergent clean but is it inexpensive, practical to use and noninjurious?

In our enthusiasm about research (like the old song about the Turkey Trot, "everybody's doing it" or wants to do it—meaning research, of course), we are likely to forget that research is broad enough to include the painter, the housekeeper, the carpenter and others. Their contributions may be of more value, both immediately and eventually, than an array of figures and an accumulation of data, imposing but nonetheless incomprehensible. Both administrator and clinician must consider the practical aspects of the research. Applicability to a great extent determines value, not necessarily brilliance and depth.

Research we know to be long, tedious and expensive. It is often disappointing in results. It may be of positive or negative value, in the sense of proving or disproving a contested point. These objections actually are minimal when compared with the possible return of a piece of research well done and practical.

The Balance Is Favorable

It has been said that the cost of a psychiatric casualty from World War I is $30,000; further, the cost of training one psychiatrist is about $25,000. Consequently, if one psychiatrist after suitable training (the close relationship between research and teaching deserves emphasis) prevents the development of one such illness, then the balance is favorable. It is even more favorable when it is considered that one psychiatrist can usually give service to more than one sick person.

Recently, General Eisenhower was quoted as saying that this country's future safety depends not on its mili-

tary resources—but on military research! All the weapons left over from the European war could be scrapped or given away if military research could continue without interruption.

The clinician rightfully expects research to be of practical value. This does not mean immediately, but certainly ultimately. Objections have been raised to research beginning and ending in the laboratory or in the library, to the relative sterility of some research workers and the narrowness of their outlook. If the researcher is distressed by criticism leveled at his residence in an ivory (?) tower, he has only himself to blame.

Psychiatric Research Now

Probably no other field in medicine, especially considering its size, has been "researched" as has been psychiatry.[1,2,3] Relatively new, for after all psychiatry as we know it dates largely from the turn of the century; given impetus by two world wars; now popularized, though this is not always favorable, psychiatry has been the object of extensive investigation as a modality per se and in its increasing relationship to other disciplines.

Two trends in particular have brought life into a field previously comparatively sterile. First, increased investigation along lines of treatment: metrazol, insulin, electric shock, malaria, the fever therapies, prolonged narcosis, narcosynthesis, the various forms of psychotherapy and many others could be mentioned.

Second, and of importance as research both in itself and as related to treatment, the investigations of the depth psychologists, analysts, clinical psychologists and psychiatrists into the structure of the personality are gradually giving the psychiatrist insight into the nature of his problem —Man.

It is well within the range of reason to say that psychiatry is still in the period where all or most of its work (referring here particularly to clinical activities) may be considered as research in character. The reason for this is that psychiatry is not as yet well formulated so that practically every observation has some potential research value. Witness to this is the recent work by Burlingame and others[4,5] relative to industrial problems. What seemed at first a comparatively restricted field became with further inquiry into it surprisingly broad and led to many new questions.

Future Psychiatric Research

It seems unnecessary and useless to try to review the many divisions of psychiatry that offer problems which should be explored. The multiplicity of the latter is astounding and disconcerting. It is better to consider the process which might yield most under present circumstances. For the moment it seems advisable to speak in terms of what the Western State Psychiatric Institute and Clinic, Pittsburgh, is planning, recognizing that these paper plans may some day mature.

Investigators, it is premised, have largely exhausted the possibilities open to solution by the individual worker. Integrated and coordinated research suggests itself for the future. Consequently, we are counting on an integrated program that will include the internist, the biochemist, the psychologist and others and, since mental illness is the focus of attention, a psychiatrist will act as director of the total program.

Further, within the next few years, we can expect to see similar coordinated research on a statewide scale, involving not only several departments in a given institution but also several hospitals studying a given problem according to the individual hospital's special interest.

Such coordinated research has much to offer. The independent worker is clearly at a disadvantage in any problem-situation of more than moderate size and complexity, as compared with the scope and flexibility of a research team. The time has passed when one man can be expected to encompass all aspects of knowledge.

While there are exceptions to the premise as stated, and while a given person may do excellent work alone, best results would seem to result when teamwork is possible. This would seem to be the experience of such centers as the Worcester State Hospital, Worcester, Mass., and the New York Psychiatric Institute. At our institute a start has been made by the joint work of the psychologist and the psychiatrist, recent work by Doctors Rosenzweig and Clark, for example.[6]

Not every physician has within himself the capacity for research work, any more than the researcher would necessarily be an equally good clinician. Recognition of these points is advantageous, for it may spare individual and institution considerable disappointment. But every doctor should be a careful enough worker to guarantee his observations a tangible and objective value.

Psychiatric research is not, or should not be, confined to the wards of the mental disease hospital. The internist and the surgeon with their ancillaries can be a part of the team, in general terms. The first step may have to be taken, of necessity, by a trained investigator but successive steps require, most of all, a willing and interested acceptance of the responsibility.

Inseparably Bound Together

At the risk of an anticlimax, one further point remains to be stressed. Clinical work, research and teaching are inseparably bound together by the spirit and necessity of study. A dominant note in each is the thought that mental illness can be prevented to a large degree by the application of broad principles, supplied by the research worker, taught to the student, utilized by the clinician.

If we accept the premise that illness is the reaction of the total person to his situation, then it follows that each observation recorded, each detail studied—clinical, social, ethical or other—is a stone on which to build. The goal toward which we should build is a sound preventive program. It promises most for medicine's future.

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[1]Whitehorn, John C.: A Century of Psychiatric Research in America, pp. 167-194, in One Hundred Years of American Psychiatry, New York, Columbia University Press, 1944.

[2]Lewis, N. D. C.: Review of the Research Work of the New York State Psychiatric Institute and Hospital for the Year 1944. Psychiatric Quarterly **19:** 219 (April) 1945.

[3]Ferraro, Armando: Recent Advances and Progressive Trend of Neuropathology in Psychiatry. Psychiatric Quarterly **19:** 267 (April) 1945.

These three articles will be particularly valuable to those interested in psychiatric research.

[4]Burlingame, C. C.: You Can Drive a Horse to Water, Mental Hygiene **29:** 208 (April) 1945.

[5]Burlingame, C. C.: Industrial Psychiatry—Facts—Not Fancy, Digest of Neurology and Psychiatry, Institute of Living, Series 13, p. 249, April 1945.

[6]Rosenzweig, S., and Clark, R. A.: The Personality of a Psychotic Ex-Soldier, Journal of Abnormal and Social Psychology **40:** 195-204 (April) 1945.

INVENTORIES—*to buy or not to buy*

Seven hospital authorities discuss the outlook with regard to purchasing in the next few months

PAUL L. BURROUGHS
Purchasing Agent
Pennsylvania Hospital, Philadelphia

OUT of the mad scramble for goods of all kinds and the general confusion following V-J Day must come a policy of realistic and objective thinking about hospital inventories. This thinking must include the speed with which reconversion progresses. It must include thinking about how fast free and private enterprise will adjust itself to reconversion from war production to peace-time production. If the same ingenuity, effort and influence are put into peace-time production that were used to feed the war machine then there need be no real shortages after a few months. Presently, then, in the face of the confusion, will the hospital:

1. Build depleted inventories up to normal times?
2. Increase stocks above normal inventories?
3. Keep low inventories in anticipation of better quality and lower prices?

1. Building depleted inventory up to normal for today assumes a low present inventory. Assuming that a low inventory is a fortunate position today, now is not the time to raise it. On some items, such as adhesive tape, a low inventory might be thirty days' supply. On chinaware, six months' supply might be a low inventory. Use judgment about the length of time and keep inventory as low as is consistent with the proper care of patients. Use up all of those war-time substitute materials. Use up all of the poor quality merchandise. Buy only currently. "Use it up, wear it out and make it do" for the next three to six months.

2. Do not increase stocks above normal. Such buying now would be sheer speculation and would serve no good purpose.

3. As users only, keep inventories low in anticipation of better quality and, in some cases, lower prices. By low inventory is meant thirty days' average. Better quality is coming, and soon, as surely as night follows day. To some extent, lower prices may come with competition but don't expect them to be lower than prewar prices. At the cost of more work on the part of the purchasing officer the policy of highly selective buying is strongly recommended.

Consider carefully all of the war surplus merchandise that will be offered for sale. There will be so-called "bargains" but remember that nothing is a bargain unless there is a real use for it. To repeat, don't speculate. Recent publicity regarding the appalling mishandling of food stockpiles shows the need for careful investigation of any items in which the hospital may be interested. Many canned foods have been in poor and inadequate warehouses for a number of years and since the tin content in the cans is so much lower than in prewar days, it follows that great care must be exercised in the purchase of these goods.

In summary, keep inventories low. Don't speculate. Don't get "fenced in" by idle inventories. Don't get blocked out on needed supplies for the proper care of patients. Don't buy surplus commodities unless you see them. Be highly selective in all purchasing and adopt the most practical procedure for these times of maintaining an inventory program in conformity with the economic and statistical status of each individual commodity.

WARREN W. IRWIN
General Purchasing Agent, University of Rochester

NORMALCY is not immediately possible. This country was not ready for war; neither is it ready for peace.

The epidemic of war has left its mark on the hospitals of America. They have suffered from lack of adequate supplies and labor, as well as shortage of professional help. Standards of operation and maintenance of equipment have fallen below desirable levels. The whole picture is one of maladjustment. That is particularly true in the matter of supplies.

Hospitals are faced with the question of "What to do in the way of inventories?" Should they try to build inventories back to normal or beyond normal or should they keep inventories low in anticipation of better quality and price?

Each hospital should carefully examine its stocks. If an inventory is not immediately available, one should be taken. This physical inventory should show how that hospital stands in the way of supplies. Inventories of some supplies will be found large, some adequate and some painfully short. This inventory will be the guide for present and future purchases.

Until the uncertainty of conditions is over and we have an opportunity to understand the full significance of world peace and its effect on business and commodity prices, purchasing agents as a general policy should watch developments carefully and buy only for short-term requirements.

No doubt we shall have some price reactions, but these should not be drastic. Commodity prices in general are being held in restraint by O.P.A. price ceilings but O.P.A. is even now raising its sights and the tendency will be to raise price ceilings to offset hardships caused by increased costs.

The O.P.A. has until June 30, 1946, to operate under its present lease on life. Price readjustments should not be rapid and no material change is expected in the near future.

Drugs and *chemicals* should not be purchased in large quantities beyond current needs. The government will not be in the market as actively from now on and available supplies should be more than ample.

Paper items will remain scarce for some time owing to the bad condition of the industry. This will be one of the last to recover. But, again, the government has been a large buyer and will not be buying as heavily. Buy what you can in this market for your needs for weeks ahead.

Textiles are short. Most hospitals need them badly. The labor situation, an inadequate and an unfair priority system and the price control measures, all contributed to this generally bad situation. These matters should be remedied quickly because of government cut-backs, available productive capacity and an increased supply of labor. Buy for current needs here. Textiles should be easily available in the early part of 1946 and perhaps sooner.

Food items are still scarce and will remain so because of crop conditions and insufficient labor for processing. Check your inventories of food carefully and buy whatever you can to take care of your needs until the next harvest or processing time. Do not overbuy; use up your old supplies to make way for the new and in all cases watch for government releases of surplus foods. But do not buy sight unseen.

Surgical dressing are and will be easily available. Already most large manufacturers are advising their trade of that fact. Prices should not rise.

Rubber goods of all sorts will become increasingly more available.

Surgical instruments will be and are being released by the Armed Services in large quantities—no large commitments should be made.

Equipment purchases should be held to immediate needs awaiting government releases and new developments.

As a general policy, keep your eyes open, stay on the sidelines and, in general, buy only for current needs until your inventories are back in proper adjustment and balance.

JAMES BEST
Purchasing Agent
New York Hospital, New York City

SUPPOSE we analyze the question: Shall we replenish shrunken inventories? A quick "yes" would seem to suffice on ordinary stocks in which no changes in manufacturing technics or constituent materials are to be made—but, hesitate for a moment! Have our inventories been too high in the past and have we awakened to the fact that we have been able to get by on much less? A minimum working inventory has been found to have many advantages, especially if no price fluctuations are present.

1. The more available materials there are, the more waste there is and the greater floor space is occupied.
2. The less capital we invest, the more money we shall have available for profitable investments.
3. If technics are to be changed, it will take longer to put them into effect if we are saddled with large stocks. The same would hold true of new developments in products.
4. With smaller holdings the hospitals is always in the market should attractive offers be made and it would have sufficient space and range in maximum inventory to accept them.

True, normal to low quantities mean a bit more purchasing effort, but the advantages would seem far to outweigh this disadvantage.

What about the second question: Should purchases be increased over a normal? The answer that seems to pop into mind immediately is to do so when canned goods particularly are concerned, especially now that ration requirements have been lifted. In certain items, such as apples, applesauce, pineapple or grapefruit juices and some others, there will be a definite shortage and above normal anticipatory buying will be advisable. On other items the decision would fall into the "no" column for reasons outlined in the answers to the first questions and to be further outlined in the comments on the third question.

The third question asks: Should the same low level as at present be maintained? I am definitely for the low inventory and for the following reasons:

1. The answers given to the first question.
2. There is no doubt but that quality during these war years has not been up to the high standard we experienced before. This has been due to a number of reasons, chief among them, lack of quality raw materials, scarcity of competent help, demands of war needs and the chaos created by the demand being greater than the supply.
3. It is fully expected that the new materials developed for the armed services will eventually be available for civilian use after surplus and present stocks are exhausted; therefore, the smart procedure would be to wait.

NEAL R. JOHNSON
Purchasing Agent, Johns Hopkins Hospital, Baltimore

THE question of inventories is one of the most disturbing problems in the minds of hospital buyers today. What should we do about inventories right now, and how should we proceed for the next six months?

The course is none too clear as almost daily changing conditions and predictions of things to come have their immediate effect upon our planning. Endeavoring to arrive at a safe and sane course to pursue, I shall attempt to answer the three questions presented.

Question 1: Should hospitals build up depleted inventories to those of normal times?

Answer: No; keep inventories as low as possible, maintaining only stocks enough to assure the smooth functioning of your institution.

Question 2: Should hospitals increase stocks above normal?

Answer: This is answered in part above, and again my answer is no, and for further reasons given below.

Question 3: Should hospitals keep low inventories in anticipation of better quality and lower prices?

Answer: Better quality goods will probably reach us, in many instances, within the next six months, but better prices are not likely to come until manufacturers' inventories have been built up until they *more* than meet consumers' demand. Without ques-

tion, O.P.A. ceiling prices should be maintained, thus, in effect, freezing present prices until production catches up with demand. Only then will we again have free markets and a competitive situation which will in itself bring about lower prices. With the advent of this situation there should be no further use for O.P.A.

There is one large fly in the ointment which may very well upset all calculations, government surplus commodities. This situation is going to bear careful watching and is one of the primary reasons why low hospital inventories should be maintained.

Under the wording of the present law governing disposal of government surpluses, voluntary hospitals have a high priority position on the list of those eligible to receive these goods. However, while one should not look a gift horse in the mouth, hospital buyers are going to have to look at a lot of these surplus goods with a careful and critical eye.

On food, my information is that the outlook for this year's pack of tomato products of all kinds including juice, apple products including juice, cherries and asparagus is extremely poor. The lima bean crop is reported to be a failure and few, if any, will be available. I believe orders should be placed for these products immediately, if you can find a vendor to supply them.

Apparently the corn pack will be adequate, but most of the pack will be of the cream style, or crushed, and very little whole kernel will be packed.

Peas, beets and string beans will probably be in good supply and should be of good quality.

More salmon and tuna will be available this season than last year but, again, to be sure of being taken care of, get your orders placed with your supplier. Neither of these items will be too plentiful.

Pineapple products will be in larger supply than last year but get your order in now to assure receiving your share.

I am advised that while there will be a larger quantity of West Coast fruits available than we had last year, this year's crop will be packed only with standard grade sirup. The supply will not be large.

Keep informed on the frozen fruit and vegetable situation; a much larger tonnage of these products will be frozen this year than ever before. It is reported that the War Food Administration will shortly release large quantities of frozen cherries from last year's crop. Ask the regional W.F.A. representative for further information concerning this. This year's cherry crop is estimated at not more than half of normal.

Unless an early statement is made by the government that large blocks of processed foods are to be released from its stocks for sale in civilian channels, hospitals must place their orders promptly for delivery from the current pack. Remember, ceiling prices are still being maintained on these items.

ROY R. PRANGLEY
Superintendent, St. Luke's Hospital, Denver

I DO NOT believe that we should immediately build depleted inventories up to those of normal times; certainly, we should not let the fear of inflationary trends cause us to build up our inventories to above normal. We should adhere to a "hand-to-mouth" buying policy, purchasing upon a three to six months' basis, until such time as we are able to do some choosing. There are, of course, some exceptions, such as textiles, paper supplies and, possibly, canned goods.

Now that the war is over, I believe that the United States will lead all the nations in the rapid conversion to peace-time manufacturing and production of goods and that it will not be long until this conversion will be completed and more manufactured items will be available than ever before.

We are, without doubt, entering the greatest era of competition among men and materials that has ever been experienced. New products will be manufactured and many improvements will be made. However, the buyer of hospital products must be thoughtful and scientific in his purchasing and sound in his judgment in order to avoid mistakes on the untried items.

Let us be cautious for the next six months in our purchasing, but let us be optimistic about the future.

In regard to the purchasing of such items of equipment as dishwashing machines, wheel chairs, carts, boilers and water softeners, the hospital buyer should remember that the government has a large surplus stock of such items that can well be adapted to institutional use. Therefore, let us wait until the government is ready to release these items, at which time we may be able to purchase them at greatly reduced prices. Certainly, hospitals have the right to benefit from the sale of surplus properties by the government.

I can cite an illustration from our own experience at St. Luke's Hospital in Denver, which shows the advantage that can be gained in this way. We shall, within the next few months, be in need of a new dishwashing machine, the cost of which is $1975, with no trade-in allowance on our old machine. One of the near-by Army camps has been abandoned, and the dishwashing machine has been sold to a dealer who will sell it to the hospital for $600 plus our old machine. If, when this item is thoroughly checked, it is found to be in good condition, its purchase will prove to be a real saving to the hospital.

We know that the government has hundreds of thousands of dollars worth of stock stored in warehouses which will be available at reduced prices to such institutions as hospitals. [*Note: It is reported that much of this material is to be given or sold at nominal rates to hospitals too poor to buy it.*—Ed.]

Competition is the buyer's answer to quality and economical buying. Our manufacturers, because of competition, will be turning out better products than ever before.

We have already seen big companies, such as General Mills, formerly in the food business, planning to add to their manufacturing lines such items as pressure cookers, electric irons and automatic coffee makers. This will give competition to the old companies that dominated this field before the war.

The hospital purchasing agent will now find that he has a host of sources of supplies that he did not have during the war. We shall be seeing our salesmen again, and we shall be having every opportunity to do selective buying. We must be

cautious until we have again found the best sources of supply and the most satisfactory products. But we are going into a wonderfully challenging era that will be extremely interesting and toward which we should be looking with great optimism.

HAL G. PERRIN

Business Manager, Municipal Hospitals, Kansas City, Mo.

THE central storeroom serving the municipal hospitals of Kansas City, Mo., will soon hold, we hope, a three months' supply of x-ray film, toilet paper and other paper products, canned fruits and vegetables and hospital textiles. Our stock on these items has been severely depleted.

Generally, however, as deliveries promise to be prompter, we intend to adopt a purchasing policy of watchful waiting—for improved qualities, better selections, new products, availability of surplus commodities and lower prices. This should result in only moderate stocks of most items for the next six to twelve months.

Undoubtedly, we shall soon see an era of active competition in many lines. Some of this is already evident. Immense production facilities, labor and materials are available and it's a good bet that the purchaser will benefit in both quality and price.

Again, because of technical advances during the war, new products will be available that will make obsolete some items now on hand and many of them will be offered to us in the next few months. We have bought our last drum of insecticide until we learn how to handle DDT. Maybe we shall buy paint with DDT mixed in; possibly this will kill insects for the life of the paint.

Now that the vendor can concentrate on our business again, we shall ask him to bid on stricter specifications. We have been developing these (with the help of other purchasers and enlightened vendors) for such items as eggs, meats, dishwashing powder, laundry soaps, floor waxes and soaps, dressings and hypodermic syringes. We are still seeking help with many items, including paints and finishes. Our specifications must be of the open type allowing at least three bidders.

In purchasing many items of large supply, we are interested in specifying accelerated tests that can be performed in our own laboratory. We intend also to use, where necessary, the services of a local impartial testing laboratory. This is an effort to get the facts before we buy.

We do not intend to forget, as far as our policy of public purchasing will permit, the service of those vendors who helped us to obtain scarce merchandise during the war period. Nor shall we forget the value of a good name when doing our buying. "The priceless ingredient" integrity, as one manufacturer calls it, haloes the price on any bid sheet. Bids being nearly equal, one naturally turns to the dealer with a reputation for good character.

To permit buying at maximum discounts and to reduce an excessive number of storeroom items, we have standardized on qualities of many commodities. For instance, it was formerly necessary, in order to please the housekeeping departments of our three hospitals, to buy three qualities of floor soap for terrazzo floors. Now one has been selected that is acceptable to all. We intend further to develop this attempt at a storeroom "formulary."

For this postwar resumption of normal buying give us the sales representative who (1) knows his product and can describe it honestly; (2) knows how to test his product fairly for efficiency, and (3) knows how to teach the purchaser to use his product properly.

HARRY C. DUNHAM

Purchasing Agent, Miami Valley Hospital, Dayton, Ohio

THE sudden ending of the war, with the consequent easing of some restrictions, has placed before us the difficult problem of determining what policy we should follow during the months directly ahead in relation to the buying and stocking of the innumerable items used daily throughout the hospital.

First, our inventories are perhaps dangerously low on some articles. Should we try and build up these depleted inventories at this time? The answer to this question is, I think, dependent entirely on the stock items in question. Many products had to be somewhat cheapened in quality during the war and we would hardly want to fill our shelves with the lower grade merchandise now if we can expect better quality in another three to six months.

Some inventory items remained almost unchanged in both quality and price, but we were placed on a strict quota basis which may have worked some hardship on the hospital to stretch the meager allotment to meet its many demands. Now, I believe we can safely build back to our normal requirements.

One thing we must not lose sight of is that even though suppliers may soon have more merchandise, we are all, so to speak, in the same boat, so the demands on these firms will be much heavier than usual; also, transportation is still critical and will remain so for some time to come so, on some items, we may have to maintain larger inventories than we would in normal times.

During the war, many small shops and factories sprung up all over the country, and I believe we can, with some justification, look for some of these plants to enter into a peacetime production of articles for the institutional trade. This will bring about an increased competition that is bound to reflect itself in better products, from the standpoints of both quality and service, at a substantial reduction in cost. New ideas and improvements are bound to be incorporated in many of our present hospital items, and we don't want our shelves to be full of merchandise that could become obsolete overnight.

Be as conservative as possible in your buying for the next few months. Protect yourself on the still scarce items, such as paper and textiles, whenever you can, even though you may for a time carry an inventory above the normal standard. On other items, if possible, adhere strictly to a hand-to-mouth buying policy for some time to come and be in a position to take advantage of an increased quality in products at lower costs in the not-to-distant future.

SMALL HOSPITAL FORUM

Surgery Presents These Problems

1. **Scheduling Order of Operations**
2. **Recording Preoperative Diagnoses**
3. **Setting Up Qualifications for Surgery**
4. **Choosing Nurse or Physician Anesthetist**

CONTROLLING the operating room, scheduling operations and providing anesthesia services bring many problems to the small hospitals of the United States and Canada. Twenty-seven of them filled out and returned questionnaires that were sent out by The MODERN HOSPITAL to 50 hospitals, ranging in capacity from 50 beds to 130. This was a high percentage of returns, 54 per cent.

One of the sometimes troublesome problems in small hospitals is to schedule operations so that the institution is fair to all of the surgeons and, furthermore, so that the surgeons think the system is fair. Twenty-one of the institutions solve this by a strict chronological system, "first come, first served."

Two of the hospitals have so few surgeons that there is no problem, particularly in view of the fact that the surgeons assist one another at operations. One hospital gives preference to doctors in order of request but "on rotation." Another says it schedules operations "in accordance with rules made by the medical staff" while another gives preference according to seniority. One did not answer.

Supervisor Plans Schedule

The surgical supervisor usually prepares the operating room schedule, this being the practice in 17 hospitals. The business or accounting office does it in three hospitals while one or two hospitals assign it to one of the following persons: superintendent, surgeons themselves, assistant superintendent, telephone operator under the general supervision of the superintendent of nurses and the operating room supervisor and the admissions clerk. Several hospitals assign the responsibility to more than one person.

Most of the hospitals seem to encounter little complaint of favoritism in scheduling operations.

Various arrangements are illustrated in the following comments:

John H. Zenger, administrator, Utah Valley Hospital, Provo, Utah, says: "At the present time we have a waiting list for surgery and reservations are scheduled in chronological order by the business office. Our surgical supervisor is in touch with the business office daily and prepares the daily schedule. No favoritism is permitted and the doctors have access to the waiting list so that they know we are impartial in scheduling operations. Occasionally we shift the order so that one man can do several cases in one morning and this meets with general approval."

At North Vancouver General Hospital, North Vancouver, B. C., Allan McLean, administrator, describes the plan as follows: "The surgeon inquires of the hospital telephone operator in person or by telephone. He is advised of the operations already scheduled and of the times open. The time selected by the surgeon, the nature of the operation, preoperative diagnosis, anesthetist, type of anesthetic and the name of the patient are then entered on the operating room register.

"As soon as is convenient, this information is reported to the operating room supervisor and is also recorded on an operating room schedule (except the name of the patient) in the doctors' room.

"The operating room schedule comes under the general supervision of the superintendent of nurses with the detailed supervision being done by the O.R. supervisor.

"Occasionally the time selected by the surgeon may not be suitable. In this case the supervisor gets in touch with him and arranges a more convenient time.

"No favoritism is shown to any surgeon and none is expected. A surgeon booking an operation has the choice of the time open. If there is no time open on the particular day he wishes to schedule a particular operation, he must select another day on which there is time open. This, of course, does not apply in the case of emergencies.

How Disputes Are Settled

"Provision is made in the operating room regulations that, in case a dispute arises over precedence in nonemergency operations, it shall be decided by the superintendent of nurses whose decision shall be final."

Billings Deaconess Hospital, Billings, Mont., sets a time limit for tardiness. Gertrude J. Buckles, superintendent, says that "if the surgeon is not on time the spot is held for fifteen minutes and then, if someone else needs it, he has that privilege."

Sister M. Cyrilla, who is superintendent and also anesthetist of St. Joseph's Hospital, Boonville, Mo., declares that "as we have only one anesthetist, operations have to be scheduled accordingly. No preference

is given to seniority and we think it is for this reason that our plan has succeeded so well."

Charles C. Warner, superintendent of Mountain State Memorial Hospital, Charleston, W. Va., will permit no trace of favoritism. "Time is allotted in the order requested. If the operating room supervisor favors any physician by holding time for him, she is immediately dismissed. Physicians looking for favors are soon found out by their fellow professional men and are ribbed by them until they will not try for favors again."

At Culver Hospital in Crawfordsville, Ind., Ralph M. Haas reports that "general surgery is scheduled on Monday, Wednesday and Friday with tonsillectomies on Tuesday and Thursday. Saturday is reserved for the surgical nurses to prepare supplies and equipment for the coming week. Emergencies are done at any time."

Eva M. Braun of Suburban General Hospital, Bellevue, Pa., says that "major operations are scheduled for three days a week, unless they are emergencies, and minors for the other three alternating days. One hour is reserved for a major operation and one half hour for a minor."

Hospitals were asked whether a preoperative diagnosis must be recorded. Twenty-six of the 27 hospitals said "Yes." Enforcement of this rule is a responsibility of the operating room supervisor (5 hospitals), clinical staff (5 hospitals), resident physician or medical director (2 hospitals), administrator (2 hospitals), floor supervisor (2 hospitals), anesthetist (2 hospitals), admitting department (1 hospital), "medical records nurse" (1 hospital), superintendent of nurses and assistant superintendent of nurses (1 hospital).

Only five of the hospitals reported that they "at times" have difficulty in enforcing this rule. Asked if they have any good method of enforcing the rule, one hospital replied: "Please tell us one."

Two hospitals withhold the use of the operating room, one prohibits the anesthetist from starting the anesthesia until the preoperative diagnosis is on the medical record, another points out to the surgeon that the hospital might lose its A.C.S. approval and that nurses can't care for patients intelligently unless they have a preoperative diagnosis. In one institution the surgeon loses his hospital privileges for ten days if he refuses to put a preoperative diagnosis on the chart.

At George Washington University Hospital, Washington, D. C., Leo G. Schmelzer says that "a physical examination is done on every patient (except possibly some emergency cases) *previous* to surgery. This must be recorded on the patient's chart. It is enforced through the department head."

Mr. Warner says that he requires "a preoperative diagnosis" prior to operation. The resident physician checks this and reports omissions to the chief of staff. "We are lenient, always have been, but if a surgeon persists, then he must do some explaining to the superintendent and chief of staff before he can operate."

Miss Braun is the one who can suspend a surgeon for ten days and "this rule is endorsed by the board of directors," she reports.

Who Does the Surgery?

A touchier problem was raised in the next question: "Can any licensed physician in the community undertake major and minor surgery in your hospital? If not, what restrictions do you have?"

Only three hospitals said "yes" to the first question, while 24 answered "no." The restrictions, however, vary widely, some apparently having to do with the quality of the doctor's surgery and others relating to extraneous matters.

The qualifications falling in the first category and the number of hospitals enforcing them for major surgery are: A.C.S. membership qualifications (1), approved surgical residency (1), at least one year of surgical residency or long experience in surgery (1), two year surgical residency (1), only members of the hospital's surgical staff (1), only senior surgeons on the surgical staff (1), only after a successful probationary period (3, one of which makes this period two years in length), only those approved by the surgical committee (1), only the resident staff surgeon (1), only active staff members in good standing (5), only active and courtesy staff members (3).

Whether the last two kinds of qualification are actually any protection to patients and the hospital against unjustified or unskillful surgery depend, of course, upon the methods followed in granting active and courtesy staff privileges.

The other group of qualifications and the number of hospitals relying on them are: membership in state

THANKS TO THESE CORRESPONDENTS

HOSPITAL	RESPONDENT	BEDS
W. B. Plunkett Memorial, Adams, Mass.	E. Vera Dean	50
Utah Valley, Provo, Utah	J. H. Zenger	50
Baton Rouge General, Baton Rouge, La.	Mrs. I. B. Stafford	55
Mount Desert Island Hospital, Bar Harbor, Me.	Anna Wild, R.N.	58
Community Hospital, Beloit, Kan.	Wanda G. West	60
Barre City Hospital, Barre, Vt.	Caroline A. Innes, R.N.	64
Johnston Memorial, Abingdon, Va.	P. S. Smith, M.D.	65
Memorial Hospital, Corpus Christi, Tex.	Fred Roberts	65
North Vancouver General, North Vancouver, B. C.	A. McLean	70
Memorial Hospital, Sheridan, Wyo.	Bertha A. Malokowsky	70
St. Luke's General, Bellingham, Wash.	Mrs. Bergit Lee Gundersen	75
Valley View, Ada, Okla.	J. O. Bush Jr.	75
Billings Deaconess, Billings, Mont.	Gertrude J. Buckles, R.N.	78
St. Joseph's, Boonville, Mo.	Sister M. Cyrilla, O.S.B.	85
St. Francis, Blue Island, Ill.	Sister M. Carmelita	85
Athens General, Athens, Ga.	Agnes P. McGinley	90
Naeve Hospital, Albert Lea, Minn.	Mary King	90
New Hampshire Memorial, Concord, N. H.	Bertha L. DeLong	91
Alameda Hospital, Alameda, Calif.	Ruth A. Wescott	97
George Wahington University Hospital, Washington, D. C.	L. G. Schmelzer	100
New Biloxi, Biloxi, Miss.	Sister M. Wilhelma	100
Mercy, Burlington, Iowa	Sister Mary Leona	100
Mountain State Memorial, Charleston, W. Va.	Charles C. Warner	100
Culver Hospital, Crawfordsville, Ind.	Ralph M. Haas	103
Beebe Hospital of Sussex County, Lewes, Del.	James Beebe, M.D.	104
Anniston Memorial, Anniston, Ala.	H. F. Singleton	105
Suburban General, Bellevue, Pa.	Eva M. Braun	130

medical society (1), residence within the city (1), doctors admitted to the hospital staff by vote of the county medical society and the hospital administrator (1). Two hospitals didn't answer.

E. Vera Dean, superintendent of W. B. Plunkett Memorial Hospital, Adams, Mass., says "Section 15 of our staff by-laws reads: 'All major surgical work done in the hospital shall be done either as an assistant to or with the assistance of a member of the surgical staff or consulting surgical staff until such time as the surgeon shall have attained the qualifications necessary for membership in the American College of Surgeons.' As we have only one doctor who meets these requirements, he does the surgery assisted by the doctor who referred the patient."

At North Vancouver General Hospital "it has not been necessary to limit by regulation the work that may be undertaken by any particular member of the medical staff. However, a check is made on surgeons not on the staff to see if they are in any way limited at other hospitals. The director of surgery, appointed by the board of management on recommendation of the medical staff, is responsible for some supervision of the use of surgical facilities. Specialists in the various branches of surgery are called in for the more serious cases."

Must Prove Their Ability

At Athens General Hospital, Athens, Ga., Agnes P. McGinley says that "the older staff men who were doing surgery when the hospital opened in 1921 were allowed to continue. All new staff members are accepted on the associate staff only for two years. During this time they prove their ability. Later the hospital will require special training."

Ten of the hospitals permit a nurse to act as first assistant to a surgeon although several qualify this permission in various ways. Two permit it only in minor surgery or "the simpler major procedures." Two permit a graduate nurse to assist in emergencies or, if she has been specially trained, in a particular type of surgery, such as eye operations. One will let a student nurse act as first assistant in a rare emergency.

Seventeen of the reporting hospitals will permit only a physician to act as first assistant. Four hospitals specifically volunteered the information that this doctor must be a surgeon; others use interns, residents or any member of the medical staff. Some use the referring doctor.

Five of the hospitals will permit an exception to be made for emergency surgery on holidays or at night. Several permit nurses as assistants in minor surgery.

Mr. McLean reports that "this point is not covered by any definite regulation of the hospital. Registered nurses act as first assistants in minor and relatively simple major operations. In all other cases a surgeon assists. Should a surgeon not arrange for an assistant when he should have one, a word to him or to the director of surgery is usually sufficient. There is usually no difference made for emergency operations. The use of physicians as assistants has been facilitated because the members of the medical staff volunteer to act as assistants whenever requested to do so by the surgeon."

This might be a good time to report a statement by an administrator who must, for obvious reasons, remain anonymous:

"As you know, no hospital is operating under ideal conditions today. In fact if the public realized how unprotected it is, we would have a panic. I know of no method that will force the medical men to work beyond their strength and the others do not care. During normal conditions one can enforce rules but if a hospital is depending upon two surgeons, one of whom is handicapped, to answer all accidents, emergencies and regular surgery service and they are very indifferent about doing this work, we are forced to accept and be grateful for what cooperation we do get.

"The war has made great demands on the younger medical men from our county. Our postwar plans are for an ideal medical staff setup and enforcement of the rules and regulations that are so necessary in giving good medical attention.

"Our first change will be to insist on a physician as first assistant. Perhaps the medical men will come to know one another better and learn to work together and understand one another. This condition exists not only here but in many hospitals. I believe conditions will not change until the A.H.A. makes an issue of it and insists on a different attitude on the part of the medical profession."

The next question was: "Do all of your surgeons insist on morning operating hours or will some of them operate in the afternoon?"

Only seven hospitals said that the surgeons all want morning hours; in 11 institutions some will operate in the afternoon. But 12 of the hospitals reported that they insist on morning hours for the convenience of the hospital and the surgical employes. Two hospitals keep their surgeries going practically all day.

Nurse Anesthetists Preferred

Nurse anesthetists are definitely the most popular in these small hospitals. Twenty-two institutions use nurse anesthetists, nine use physician anesthetists and six use general practitioners. Some use both nurses and physicians.

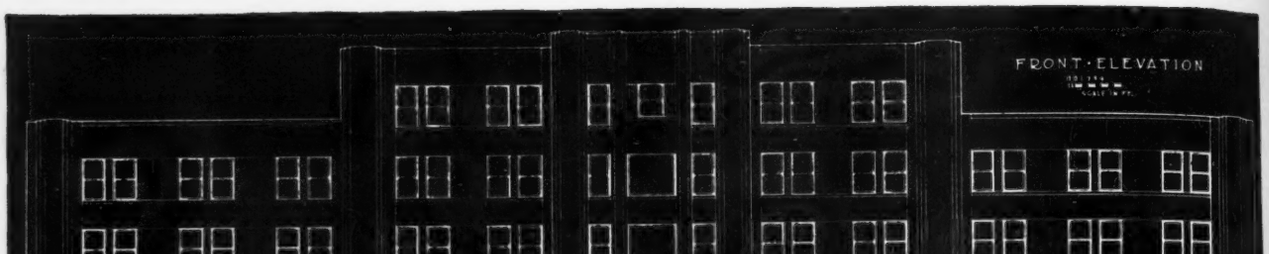
Asked which plan they prefer for hospitals of less than 100 beds, 15 favor nurse anesthetists, two favor physician anesthetists, two favor general practitioners, two want to use both physician and nurse anesthetists and one prefers a physician anesthetist with general practitioners filling in.

Bertha L. DeLong of New Hampshire Memorial Hospital, Concord, N. H., has both nurse and physician anesthetists but says "I think a physician is always preferable."

Directly contrary is the opinion of Sister M. Wilhelma of New Biloxi Hospital, Biloxi, Miss., who says that "having anesthetics given by a nurse is the best arrangement for the hospital of less than 100 beds because of the difficulty of getting a doctor at any time; also the nurse anesthetist takes such an interest in her work."

"In normal times I feel that a nurse anesthetist should be used only when it is impossible to get a physician to give the anesthetic," says Mr. Warner. "The fees thus collected by young physicians are of great assistance in getting them started and this has been a very good way to create good will between the young doctor and the hospital. Most young physicians have had good training in anesthesia and are anxious to do the job well."

As is pointed out editorially in this issue, however, the development of new anesthetic drugs and new methods of administration has made this point of view obsolescent.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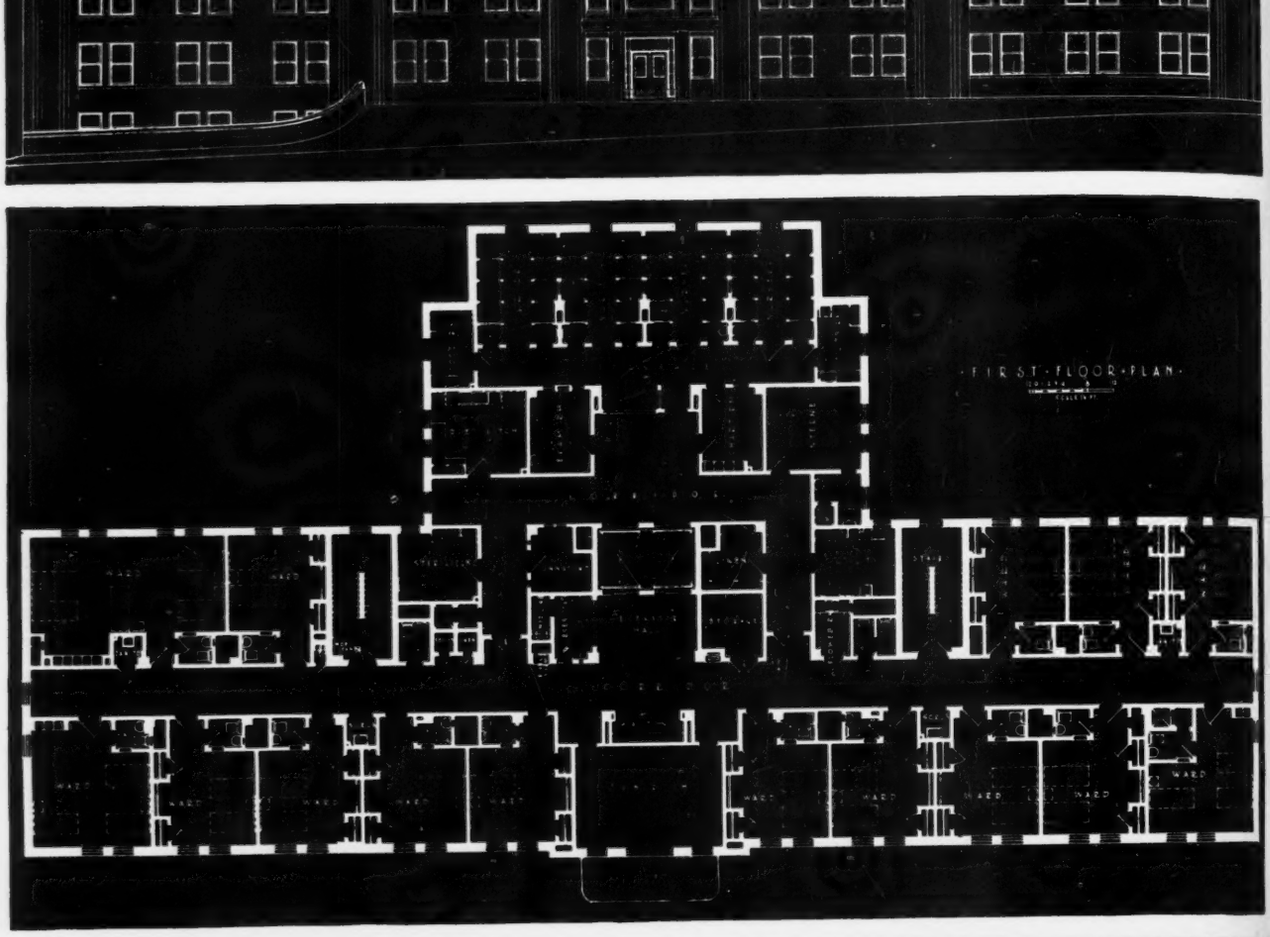
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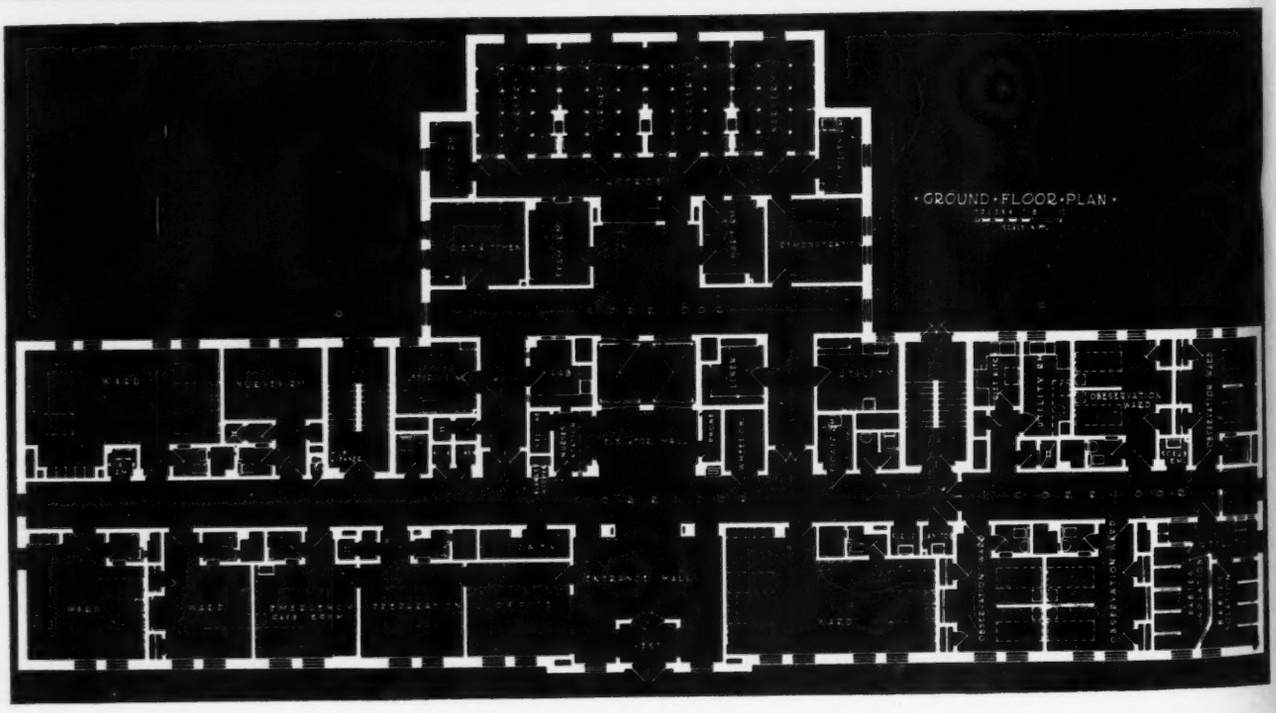
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MATERNITY WING—ROYAL JUBILEE HOSPITAL, VICTORIA, B. C.

H. WHITTAKER
Chief Architect
Department of Public Works, Victoria, B. C.

GENERAL DATA: New wing at the Royal Jubilee Hospital serving, along with a Sisters' hospital in the same city, a population of 100,000 people.

CAPACITY: Patients—59 normal; 8 observation. Cribs—80 normal; 8 observation; 8 premature. In case of necessity all private wards on second floor can be used as semiprivate wards, increasing capacity from 59 to 75. All these wards have all facilities for semiprivate use.

CONSTRUCTION: Reenforced concrete throughout, connected to main hospital and kitchen by tunnel. All straight slab construction. Tar and gravel roof. Projecting canopy of reenforced concrete. Sash, sliding, weatherstripped and screened with roller screens.

FLOORS: Terrazzo, in all rooms having water service; AA battleship linoleum in remainder.

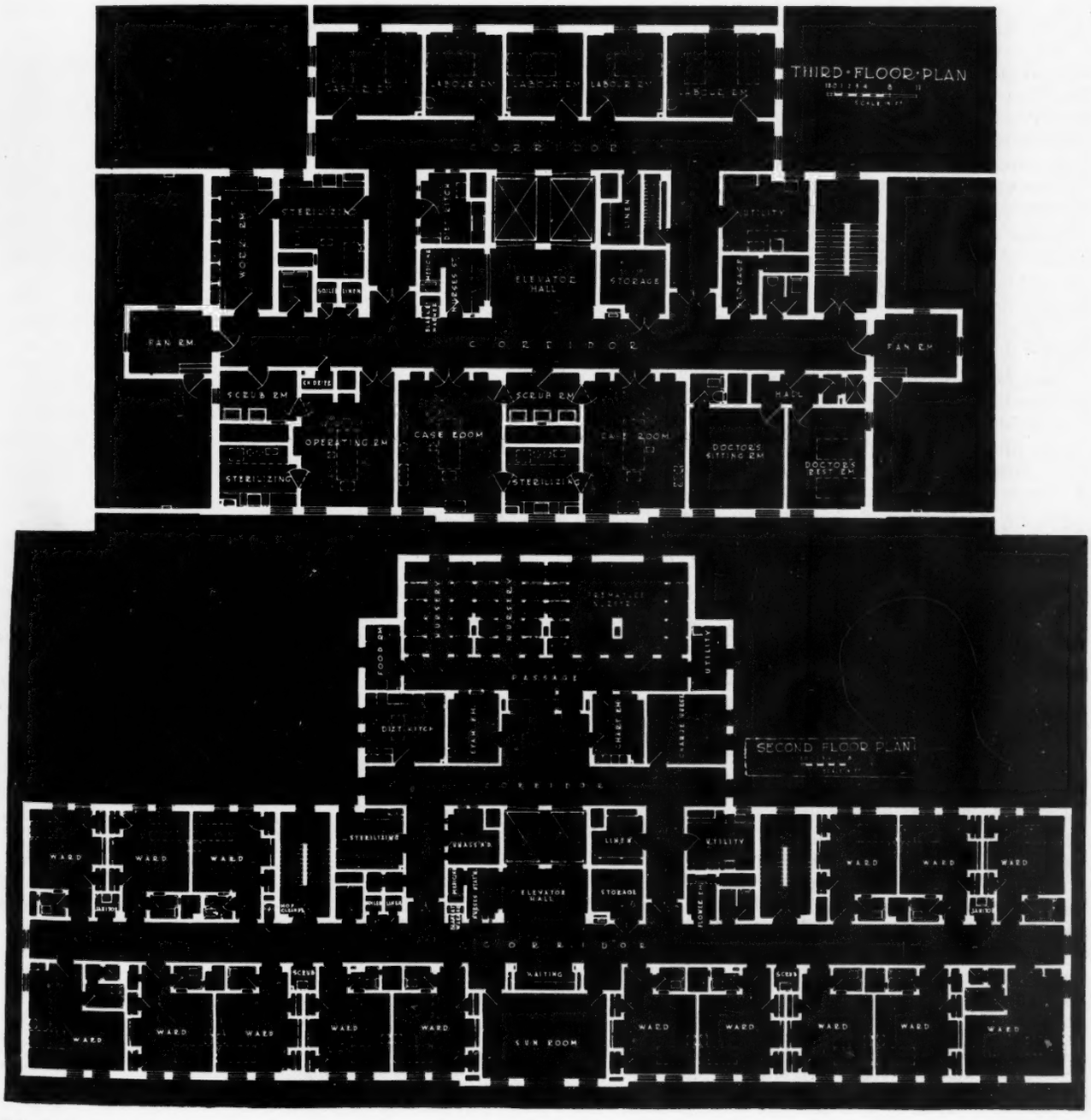
WALLS: Acoustical plaster in all corridors, service rooms, nurseries and labor rooms; mahogany veneer walls and trim in entrance hall. Tile 4 feet, 7 inches high in all service rooms, case rooms, operating rooms. External walls painted with cement paint. All painted in pastel colors.

HEATING AND AIR CONDITIONING: Direct steam and radiation to all rooms from existing boiler plant. Premature nursery, conditioned air humidified and sterilized by germicidal lamps in system. Separate control for case rooms, nurseries and operating rooms.

ELECTRICAL SYSTEMS: Nurses' call system, with corridor lights and calls to nurses' station and other service rooms. Also, communicating system from all beds to nurses' station. All rooms wired for radio to each bed.

ELEVATORS: Two standard passenger elevators, 100 feet a minute.

COST: Approximately $310,000, including tunnel. Cost per cubic foot, 60 cents. Cost per adult bed (67 beds), $4627.



About People

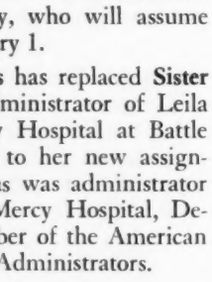
Administrators

Dr. Albert C. Kerlikowske has been named director of the University Hospital, Ann Arbor, Mich., by appointment of the regents of the University of Michigan. Doctor Kerlikowske succeeds **Dr. Harley A. Haynes** who is retiring as director of the 1000 bed institution, one of the largest teaching hospitals in the world. Doctor Kerlikowske, a native of St. Joseph, Mich., came to the hospital in 1923 as an intern and has been assistant director since 1928. He previously served as chief resident physician. Doctor Haynes was director of the hospital from Sept. 15, 1924.

Capt. E. E. Salisbury, M.A.C., is at present assigned to the Oak Ridge Hospital, Oak Ridge, Tenn., as director. Captain Salisbury spent a year and a half in the New Hebrides Islands where he was assigned with the 25th Evacuation Hospital organized from West Suburban Hospital at Oak Park, Ill. He hopes to return to the Chicago Hospital Council from which he is on leave of absence. He was executive secretary of the council prior to entering the Army.

George von L. Meyer has resigned as director of Children's Hospital in Boston. He will be succeeded by **Dr. Charles F. Branch,** dean of the school of medicine at Boston University, who will assume his new duties January 1.

Sister M. Nicholas has replaced **Sister M. Constance** as administrator of Leila Y. Post-Montgomery Hospital at Battle Creek, Mich. Prior to her new assignment, Sister Nicholas was administrator of Mount Carmel Mercy Hospital, Detroit. She is a member of the American College of Hospital Administrators.



W. N. Walters resigned as superintendent of Baroness Erlanger Hospital and T. C. Thompson Children's Hospital, Chattanooga, Tenn., on October 1. He is a member of the American College of Hospital Administrators and is a former superintendent of Lewis Gale Hospital, Roanoke, Va. He has been president of the Virginia Hospital Association and is president-elect of the Tennessee Hospital Association and chairman of the committee to make a hospital survey for the state of Tennessee.

Isabel Baird has resigned her position as assistant administrator of Waltham Hospital, Waltham, Mass., to become a member of the department on hospital relations of the Blue Cross and Blue Shield, Boston.

Dr. Lloyd H. Gaston has been appointed assistant director of St. Luke's Hospital, New York City, succeeding **Dr. Maynard W. Martin** who resigned to become director of St. Luke's Hospital, St. Louis.

Louis Liswood of Newcastle, Pa., has been named superintendent at the National Jewish Hospital in Denver. He is a graduate of the University of Chicago course in hospital administration.

In his new post, Mr. Liswood will coordinate all nonprofessional departments under the supervision of **Samuel Schaefer,** executive director, and **Dr. Charles J. Kaufman,** medical director.

Robert H. Keiser has been chosen administrative assistant and **Warren W. Butler** has been named purchasing agent at George F. Geisinger Memorial Hospital, Danville, Pa.

Rev. John R. Bucknell has resigned as superintendent of West Nebraska Methodist Hospital, Scottsbluff, Neb., to enter the active pastorate of the Methodist Church. He will be succeeded by **Rev. E. E. Pengelly** of Friend, Neb.

Dr. R. R. Hendrickson has returned to Sand Beach Sanatorium at Lake Park, Minn., as superintendent of the bi-county sanatorium, operated by Clay and Becker counties. On leave since April 1943 while serving as surgeon in the reserve with a rank of major in the U. S. Public Health Service, Doctor Hendrickson was recalled by the sanatorium commission following the recent resignation of **Dr. John Nelson Ewbank,** acting superintendent for the last two years.

Elmer Ahlstedt, administrator of Trinity Lutheran Hospital, Kansas City, Mo., has accepted the post of administrator of Asbury Hospital, Salina, Kan. **Erland Carlson** succeeds Mr. Ahlstedt at Trinity Lutheran Hospital.

Nellie L. Blinn has resigned as superintendent of Porter Hospital, Middlebury, Vt., effective October 15.

Maud A. Miles, superintendent of Peterborough Hospital, Peterborough, N. H., since 1940, resigned on October 31. A trustee of the New Hampshire and New England Graduate Nurses' associations and a nominee of the American College of Hospital Administrators, Miss Miles has been a hospital administrator since 1931. She is president of the New Hampshire Hospital Association.

Emery K. Zimmerman was appointed administrator of Elkhart General Hospital, Elkhart, Ind., recently. He was assistant superintendent of Highland Park General Hospital, Highland Park, Mich.

Ray E. Brown is the new assistant superintendent of University of Chicago Clinics. A native of South Carolina, he obtained the bachelor of science degree from the University of North Carolina in 1937. He received the M.B.A. degree from the University of Chicago this year.

Mr. Brown was county manager of Cleveland County, North Carolina, from 1937 to 1940 and superintendent of Shelby Hospital from 1940 to 1942. From October 1942 to June 1943, he was a student at the University of Chicago in the graduate course in hospital administration.

Prior to his new appointment, Mr. Brown was superintendent of the North Carolina Baptist Hospital of the Bowman Gray School of Medicine, Winston-Salem, N. C.

Reid Holmes, administrative assistant at Duke University Hospital, Durham, N. C., will succeed Mr. Brown at Winston-Salem.

Catherine M. Maloy has accepted an acting appointment at Chicago Lying-In Hospital and Dispensary in the absence of **Stanley A. Ferguson** who is on duty in the Pacific Area. Miss Maloy will serve also as assistant director of the course in hospital administration under Dr. Arthur C. Bachmeyer at the University of Chicago.

Sister Mary Edmunda, R.N., has assumed her duties as administrator of St. Joseph's Mercy Hospital, Dubuque, Iowa, at which institution plans are being formulated to enlarge to 300 bed capacity. She is a member of the

(*Continued on Page* 158)

HEADLINE NEWS

Hospital Strike Set for October 15 Averted; Dispute Being Settled

Labor difficulties which for more than two years have threatened four voluntary hospitals in Greater New York and Brooklyn, namely Beth-El, Beth Moses and Israel Zion in Brooklyn and Beth Israel in New York, and which promised recently to result in a strike of some 1500 workers, are now in process of adjustment.

Beth Israel, under direction of the War Labor Board, has agreed to negotiate a new contract with the union. As we go to press, the other three institutions are now in conference to formulate a policy regarding the union's demands for recognition.

The original difficulty arose over the contention of Hospital Employes' Union, Local 444, State, County and Municipal Workers of America, C.I.O., that the four hospitals cited had refused to adjust wages and hours in accordance with the National Wage Stabilization policy and War Labor Board procedure.

The matter was referred to national War Labor Board headquarters in Washington on appeal of the hospitals based on the grounds that the regional board lacked sufficient power for such directives. The national War Labor Board rejected the petition of the hospitals and directed a general wage increase of 4 cents an hour, which it made retroactive to July 1943.

It was the alleged refusal of the hospitals to abide by this decision that precipitated the strike action which has now been met through mediation.

The retroactive wage increases amount to approximately $150,000.

Navy Lowers Point Score

WASHINGTON, D. C.—A new critical point score became effective November 1 that will effect the release of 4000 medical officers of the Naval Reserve by January 1. The new order established a critical score of 53 points for male medical officers, a reduction of seven points from the figure in effect since September 15. Only 1700 medical officers would have been eligible for release by the first of the year under the 60-point score discharge system. Any further changes in the critical score will depend chiefly on the rate of general demobilization. The yardstick now in use is to release three medical officers per thousand men demobilized.

Young Men With Vigorous Ideas Win Modern Hospital Essay Contest

Hospital treatment for psychiatric patients gives promise of speedy improvement when young psychiatrists and allied workers get home from war assignments and put their ideas into operation.

Out of 204 entries in The MODERN HOSPITAL's prize competition for essays on "A Plan for Improving Hospital Treatment of Psychiatric Patients," the prizes and special mentions go predominantly to the younger group of professional men. In fact, the combined age of the three cash prize winners is only 92 years.

The first prize of $500 goes to **Lt. (j.g.) Lester Lee Hasenbush, U.S.N.R.,** a psychiatrist, 31 years old, and to **G. A. Hasenbush,** a graduate social worker, as co-authors.

To a 24 year old attendant at Norwich State Hospital, Norwich, Conn., **Gerard Victor Haigh,** goes the second prize of $350.

An Austrian born and educated psychiatrist, **Dr. Kurt R. Eissler,** now a first lieutenant in the U. S. Army, gets the third prize of $150.

Honorable mention in the competition goes to the following, only one of whom is a seasoned worker in the field.

Milton Lozoff, M.C., U.S.N.R., 31 years old, and **Marjorie Morse Lozoff.** Doctor Lozoff, before joining the Navy, was a psychiatrist on the staff of the Menninger Clinic, Topeka, Kan.

Dr. George H. Preston, commissioner of mental hygiene, Baltimore, Md.

Francis B. Rice, Siloam Springs, Ark.

Lt. Comdrs. Howard P. Rome, 35 years old, and **Robert S. Wigton,** 34 years old, of the Bureau of Medicine and Surgery of the Navy Department; both are psychiatrists. Doctor Rome is from Philadelphia and Doctor Wigton from Omaha.

Maj. Stanley Stellar, M.C., 31 years old, who has been serving overseas with the 16th General Hospital.

Announcement of the prize winners took place at the annual meeting of the National Committee for Mental Hygiene at the Waldorf in New York City. Dr. Robert H. Felix of the mental hygiene division, U. S. Public Health Service, one of the judges, announced the winners for The MODERN HOSPITAL at a luncheon on November 2.

The other judges in the contest were Dr. George S. Stevenson, medical director of the National Committee for Mental Hygiene, who was chairman of the jury, and Dr. Karl M. Bowman, president of the American Psychiatric Association.

Doctor Hasenbush, winner of the first prize, is a graduate of Johns Hopkins, has served at Beth Israel Hospital, Boston, and was on the staff of the Neurological Institute, Columbia University, when he joined the Navy. He was serving as separation officer at Bremerton Navy Yard when his essay was submitted.

Gerard Haigh, second prize winner, is acting in the mental hygiene program of Civilian Public Service, the group of young men whose scruples prevented them from serving as combatants during the war but who have done so much to raise the level of attendant care in mental disease hospitals.

Only 24 years old, Haigh has been engaged in boys' work, first with the Y.M.C.A. and later as partner with Edgar Deskins in Boys Village, a farm home experiment for delinquent boys. Haigh was assigned to Norwich State Hospital in September 1944.

Doctor Eissler received his degree from the University of Vienna in 1937, came to the United States before the Austrian *Anschluss* and was licensed to practice here in 1939. He was associated with the University of Chicago Clinics as a psychiatrist until he entered the Army as a first lieutenant two years ago. He is at present attached to the 172d Evacuation Hospital, Fort Jackson, S. C.

No awards in this competition were won by hospital administrators although a number of heads of psychiatric hospitals entered the competition.

Companion Bills to Welfare Act

WASHINGTON, D. C.—A companion bill to Sen. Claude Pepper's S. 1318, the "Maternal and Child Welfare Act of 1945," was introduced in the House by Mrs. Norton September 5 and again by Mr. Kelley of Pennsylvania on September 11. The Norton Bill would provide for the general welfare by enabling the several states to make more adequate provision for the health and welfare of mothers and children and for services to crippled children.

Veterans Administration Acts to Improve Medical, Hospital Care

WASHINGTON, D. C.—The special medical advisory group to the Administrator of Veterans Affairs has approved the efforts of General Omar N. Bradley to bring about improvement in the medical and hospital care of veterans.

Among the proposed plans for reorganization of the Veterans Administration are the following:

1. Creation of a full-time medical corps in the Veterans Administration, as set forth in H.R. 4225.
2. Liberal utilization of the best medical aid obtainable in civilian practice on a part-time basis, specialists on part time to be used both in hospitals and on outpatient service.
3. Location of major hospitals in or close to urban medical centers.
4. Comprehensive program in cooperation with civilian medical centers for creating and maintaining a high professional standard in the regular corps by establishing residencies and internships in hospitals, by reducing administrative work of doctors and by daily contact with part-time consulting staffs of outstanding men in the medical profession.

Maj. Gen. Paul R. Hawley, recently appointed acting surgeon general of the Veterans Administration, has estimated that the V.A. will need 5000 full-time doctors within the next few months and 7500 doctors within the next ten years.

Dr. Paul B. Magnuson of Chicago, one of the country's outstanding surgeons and orthopedic specialists, has accepted a position with the Veterans Administration to develop the research and postgraduate training program in veterans' hospitals throughout the country. Such a program, in the opinion of General Hawley, should do more than anything else to improve the quality of medical treatment in veterans' hospitals.

The House Veterans Committee has informally agreed that General Bradley should have power to hire and fire Veterans Administration doctors without regard to Civil Service and that he should be permitted to dismiss doctors now protected by Civil Service if they are incompetent and inefficient and replace them with the best the country has to offer.

Thirteen branch offices of the Veterans Administration, each under the direction of a deputy administrator, have been established as a step toward decentralizing administration.

Expand Benefits Under E.M.I.C. Program

WASHINGTON, D. C.—Wives and babies of recently discharged servicemen, under certain conditions, are now eligible to receive medical and hospital care under the Emergency Maternity and Infant Care Program.

A serviceman's wife may now apply for care for herself and for her baby after her husband's honorable discharge from service, provided that at any time during her pregnancy he was in the fourth, fifth, sixth or seventh pay grades of the services or was an aviation cadet. The same holds true in case the husband or father is a prisoner of war, missing in action or dead or has been promoted.

Heretofore, in order to get the benefits of this program, application for maternity or infant care had to be made while the husband or father was still in service in these specified grades. No application is considered when the serviceman has been dishonorably discharged.

A total of 921,169 servicemen's wives and babies had been accepted for care from the start of the E.M.I.C. program in March 1943 up to August 1 of this year. Of this total, 816,721 were maternity cases and 104,448 were infant cases.

Hospitals Are Included Under Public Works Bill

WASHINGTON, D. C.—Governmental hospitals and nurses' homes are counted among "public works projects" in a bill introduced recently to encourage the provision of useful public works.

A billion dollars a year for each of the three fiscal years subsequent to the approval of the act would be made available to F.W.A. for loans and grants to public agencies for public works projects.

"Public agencies" is defined in the bill as meaning states and their political subdivisions; "public works projects" shall include the construction, design, improvement, extension, equipment, alteration and acquisition and the improvement, repair, preliminary or temporary operation or reconstruction of waterworks, hospitals, nurses' homes and schools.

Local supervision of a hospital or control over the administration, operation or personnel is carefully safeguarded against federal interference in the bill which prohibits any federal agency or officer from "exercising any supervision or control over any hospital or school with respect to which any funds have been or may be expended under this act."

Public Benefit Program Will Help Hospitals Obtain Surplus Property

By EVA ADAMS CROSS

WASHINGTON, D. C.—The Surplus Property Administration, recently reorganized under a single administrator, W. Stuart Symington, has gone on record as declaring that property utilizable by health and educational institutions should be made available to them in as large quantities as possible and at the lowest possible cost.

Under the Surplus Property Act, surplus medical supplies, equipment and property suitable for use in the protection of public health, including research, may be sold or leased to state and local governments, tax-supported medical institutions and nonprofit hospitals.

Procedures are being established to permit needy health and educational institutions, as well as needy nonprofit organizations that are not government-supported, to obtain surpluses at discounts that will range down to nominal prices.

The Office of Surplus Property Utilization, U. S. Public Health Service, headed by Dr. Joseph O. Dean, is a part of the Public Benefit Program and will administer procedures for special treatment of tax-supported and nonprofit claimants as provided by law.

F. Hazen Dick, secretary of the A.H.A. Council on Administrative Practice, has been granted a leave of absence to serve as chief of the medical supply section under Doctor Dean.

A nine day training course, the first of a series, was recently completed during which personnel of the Office of Surplus Property Utilization was oriented to policies and procedures relating to the utilization of surplus property in the field of public health.

The Navy has adopted a new speeded-up procedure for releasing surpluses of critical items needed by the civilian economy. As a result, more than $100,000,000 worth of such items has been cleared by the various Navy bureaus and are now being declared as surplus for disposal to the public. The Navy's policy is to release the maximum possible amounts of materials that are in short supply.

Among products and materials cleared by the Navy are: $900,000 worth of medicines, drugs and bandages; 2,000,000 feet of fire hose; 300,000 square feet of copper screening; 13,000 metal garbage cans; 1300 gasoline engines; 1000 diesel engines, ranging from 60 to 200 horsepower; 2500 generator units, valued at more than $3,000,000, and 14,000 transformers ranging from ½ to 75 Kva.

Earn-While-Learning Program for Therapists Starts November 1

WASHINGTON, D. C.—Gen. Omar Bradley, Veterans Administrator, recently approved a twelve months' "earn-while-learning" program for 72 men and women who will take courses under Veteran Administration sponsorship. The courses will be given at the Philadelphia School of Occupational Therapy and the St. Louis School of Occupational Therapy and Recreation. The program is aimed at meeting the expanding needs of the agency for trained occupational therapists.

Courses for 36 students at each school were scheduled to open November 1. The age limit for students is 35 years and they must be graduates of an accredited college. Applicants accepted as students become employes of the Veterans Administration as occupational therapy trainees. After satisfactorily passing the school curriculum, students continue their courses and receive eight months' clinical experience at veterans' hospitals as apprentice occupational therapy aides.

Navy Ends Contracts Valued at $11,500,000

WASHINGTON, D. C.—The Bureau of Medicine and Surgery is terminating contracts valued at $11,500,000, according to V/A Ross T. McIntire, surgeon general of the Navy, recently. Many of the cut-back contracts are for drugs, biologicals, chemicals, surgical instruments, dental items and other supplies that can be channeled speedily into civilian markets.

An appreciable proportion of the material for which contracts are being terminated was not scheduled for delivery for several months. This fact will minimize disrupting effects, he said, upon manufacturing and fabricating plants involved.

In surgical supplies, the surgeon general said, the termination amounted to $2,941,000; for hospital and nursing equipment, $1,912,000; office supplies, $6000; office equipment, $19,000; dental supplies, none; dental equipment, $164,000; filing supplies and equipment, $1,524,000, and books, $13,000.

A.M.A. Delegates to Meet

The house of delegates of the American Medical Association will meet in a four day session beginning December 3 at the Palmer House, Chicago. Approximately 200 delegates and officials of the association are expected from all parts of the country.

Civilian Production Administration Takes Over Functions of W.P.B.

By EVA ADAMS CROSS

WASHINGTON, D. C.—The War Production Board was abolished November 3 by an executive order of the President and in its place a Civilian Production Administration was established.

Function and powers transferred to C.P.A. will be utilized to further a swift and orderly transition to maximum peace-time production in industry, free from war-time or government controls, and with due regard for the stability of prices and costs.

Some 40 controls of the original 700 are left for the new agency to handle. The C.P.A. will last only so long as these controls are considered necessary. J. D. Small, former W.P.B. chief of staff, is administrator of C.P.A.

Through its six main functions C.P.A. will:

1. Use its powers to expand production of materials in short supply.
2. Limit the use of materials that are scarce.
3. Restrict the accumulation of inventories so as to avoid speculation, hoarding and unbalanced distribution which would curtail total production.
4. Grant priorities assistance to break bottlenecks that threaten to impede the reconversion process.
5. Facilitate the fulfillment of relief and other essential export programs.
6. Allocate scarce materials or facilities necessary for the production of low-priced items essential to the continued success of the stabilization program.

C.P.A. is retaining within its organization W.P.B. specialists in, and controls over, steel, textiles, chemicals, lumber, tin, lead, rubber and other scarce materials.

Before W.P.B. was abolished it announced that the AA rating system and the Controlled Materials Plan would expire by the end of September. After September 30 the new MM military rating and the nonextendible CC rating designed for use only to break bottlenecks to reconversion went into effect.

C.I.O. Sponsors Wing for Child Patients at Georgetown Hospital

WASHINGTON, D. C.—A completely equipped wing for children in the new Georgetown University Hospital, Washington, D. C., was announced recently by Philip Murray of the C.I.O., as a living memorial to the late President Roosevelt. The memorial wing sponsored by the C.I.O. will comprise the west section of the fifth floor and will be equipped to care for some 100 children. The C.I.O. executive board has appropriated $55,000 for the hospital gift.

The proposed children's wing will include a playroom, a sundeck, two wards with five beds each, two wards with 10 beds each and 10 wards with three beds each. There will also be four semiprivate rooms, three private rooms, two observation rooms, a consulting room, dietitian's and nurses' quarters and treatment room.

The entire cost of the wing will total $165,000 with the government contributing $110,000 and the C.I.O., $55,000.

More Hospital Beds for Veterans Approved

WASHINGTON, D. C.—President Truman has approved construction of four hospitals for veterans, according to an announcement of the Veterans Administration. The buildings are: an 1800 bed neuropsychiatric hospital at Camp Reynolds, Greenville, Pa.; a 300 bed general medical and surgical hospital at Seattle; a 250 bed general medical and surgical hospital at Fresno, Calif., and a 250 bed general medical and surgical hospital at Iron Mountain, Mich.

An Army Air Forces hospital, formerly the Nautilus Hotel, at Miami Beach is being transferred from the Army to the Veterans Administration; it is a 350 bed general medical and surgical hospital.

Gen. Omar Bradley announced early in October that a 1000 bed general hospital for veterans will be erected in Brooklyn, N. Y., on an 18 acre site in the Fort Hamilton Military Reservation. It will cost $6,000,000.

Lift Convention Ban

WASHINGTON, D. C.—The ban on conventions, group meetings and trade shows was removed October 1. Lifting of the restrictions was recommended by the Office of War Mobilization and Reconversion, at whose instance such restrictions were imposed. The lifting of the ban is not an invitation to travel, O.D.T. warned, nor can it be considered an assurance that transportation or hotel capacity will be available. Sponsors of group meetings, conventions and the like have been asked to defer meetings whenever possible and to keep necessary gatherings small until after the peak of the troop movement.

Navy Makes Plans for Hospital Needs Following War's End

By EVA ADAMS CROSS

WASHINGTON, D. C.—With the number of patients increasing for the next few months in naval hospitals within the continental limits of the United States few naval hospitals will be relinquished in the immediate future, V/A Ross T. McIntire, Surgeon General, U. S. Navy, stated recently. When the time comes, he said, the first to go will be the so-called special or convalescent hospitals.

All such hospitals, 13 in number, are housed in privately owned buildings that were volunteered to the Navy. The Veterans Administration will receive three hospitals from the Navy as soon as they can be released. They are the 1000 bed facility at Dublin, Ga., and two smaller ones in Texas.

The patient census for the week ended August 15 in naval hospitals in the United States was 89,798. The normal capacity of these hospitals is 72,531, but the use of double-deck beds and adoption of other emergency measures has sent the present actual capacity to 100,000. There are in operation in continental United States 54 naval hospitals. Of these, 40 are general hospitals, 13 are for the care of convalescent patients and one serves principally as a distribution hospital.

Plans are well under way to establish a 1500 bed naval hospital at Camp Wallace, Tex., utilizing facilities which have been turned over by the Army. Camp White, Ore., another Army transfer, will furnish a 1500 bed facility. Still another transfer is Camp Phillips, Kan., which the Navy expects to get from the Veterans Administration. This one also will be transformed into a 1500 bed naval hospital.

Other postwar hospital plans call for: a 500 bed hospital at Beaufort, S. C., to replace the outdated naval hospital at Parris Island; a 1000 bed hospital at St. Albans, Long Island, N. Y., to serve as the main institution of its kind in the Third Naval District, taking the place of Brooklyn Naval Hospital; another new plant of the same size to fulfill the same purpose for the San Francisco Bay area; investigation of the need for establishing, probably in the central part of the country, a 1500 bed hospital for psychotic cases, and a study of the need for a permanent tuberculosis treatment center on the East Coast.

Army Hopes to Interest Doctors and Nurses in Staying in Service

WASHINGTON, D. C.—The Army is attempting to interest its doctors in making a career of regular Army service, according to a statement by Maj. Gen. Norman T. Kirk released recently. In addition to security, pensions, hospital care and other traditional attractions, General Kirk announced that special courses are being set up to enable Army doctors to qualify for certification by the specialty boards and internships are to be established in Army hospitals. There will also be fellowships and special courses.

Doctors who have been doing administrative work and find that their clinical skills have become rusty will serve as understudies with doctors in professional practice.

The Army will attempt to interest in Army careers the medical students who are in the upper third of their classes.

Army nurses will also be needed in the regular Army's peace-time establishment. Until appropriate legislation is enacted, the War Department cannot announce the conditions that will govern selection of nurse officers or the number required. Nurses who have too many points to remain in service at this time may file a statement of interest and be separated from active duty without prejudice to their chances of being tendered a commission when legislation is enacted.

Navy Offers Career to Reserve Officers

WASHINGTON, D. C.—The Bureau of Medicine and Surgery called the attention of all reserve medical officers who are interested in and eligible for transfer to the Medical Corps of the Navy to new opportunities for medical careers in the Navy.

Benefits, retirement, promotion and other information will be outlined to interested candidates. A residency type of graduate training program has been established in naval hospitals.

Office of Naval Research Proposed

WASHINGTON, D. C.—A bill was introduced October 9 in the House to establish an Office of Naval Research in the Navy Department. A chief of naval research would be appointed by the President to head this office. It would provide a single office which by contract and otherwise would be able to obtain, coordinate and make available to all bureaus and activities in the Navy Department worldwide scientific information and the necessary services for conducting specialized and imaginative research. A naval research advisory committee would be established to consult with and advise the chief of such office in matters pertaining to research.

OUTLOOK FOR TEXTILES

Hospitals no longer get priorities assistance for the purchase of Class A and B sheetings used for bed linens, hospital gowns and other uniforms. In removing controls as critical shortages are alleviated, W.P.B. on October 12 stated that institutions can now supplement their requirements for sheetings with such materials as drills, twills, jeans and lightweight ducks.

In early October also the O.P.A. increased ceiling prices on several types of bed linens to consumers to reflect higher prices required at the manufacturing level.

Higher ceilings had previously been announced for towels, flannels, print cloth and osnaburgs, items which had been held back because mills were waiting for higher ceilings. Although this price relief may bring more of these textiles to the market, the Hospital Bureau of Standards and Supplies warns that too much optimism is unwarranted inasmuch as the new ceilings are based on prevailing wage scales which may be raised again in the near future.

In the final quarter of 1945, more cotton fabrics will be woven for later use in the manufacture of such items as nurses' uniforms and low-priced garments than in any quarter since 1942.

Navy Releases Nurses; 30 Per Cent Want to Stay

WASHINGTON, D. C.—About 2000 naval reserve nurses will be released under the Navy's point system by February, according to Capt. Sue Dauser, superintendent of the Navy Nurse Corps. By September 1946, it is estimated that 7000 will have been released.

Officers of the nurse corps released under the point system will retain their appointment in the Volunteer Naval Reserve, thereby providing the Navy with a strong peace-time reserve of nurses. They may volunteer for active duty if there is work for them, but they will not be obligated to serve except in time of war or emergency.

Captain Dauser cannot predict the size of the peace-time regular nurse corps until Congress sets the strength of the Navy. She thinks, however, that the number might run three times higher than the 828 nurses on active naval duty Dec. 3, 1941.

About 30 per cent of the Navy nurses have indicated a wish to continue active duty.

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1. Sloping walls make for more complete sedimentation. Red cells don't hang up.
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3. Easy, natural sedimentation afforded by Sediflasks doesn't damage cells. Hemolysis is minimal, with less free potassium likely to invade plasma. Moreover, such potassium as is released disperses more slowly, due to smaller interface between cells and plasma.

The Sediflask, with A.C.D. Solution, is ideal for both whole blood and plasma, as the plasma from blood not administered within 30 days may be aspirated off without the need of expensive and scarce machinery.

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CONDUCTED BY RAYMOND P. SLOAN

"Business" *vs.* "Community" Boards

RAYMOND P. SLOAN

IN CONSIDERING the function and size of a hospital board, one trustee writes: "It seems to me you have a fundamental question of whether the hospital board is a business board or a community board. For instance, a community chest, to my mind, must have a large board to give adequate representation geographically, also from the standpoints of race, color, creed and social status. The community chest should also, in my opinion, rotate. The board of directors of a business, on the other hand, is much more likely to be efficient if it is relatively small in number and constant in service. The question in my mind, then is—should a hospital board lean toward the business approach or should it lean toward the community approach?

"Putting this another way around, why wouldn't a hospital with a board of say 15 and an executive committee of say five operate most efficiently? And why couldn't it adopt the rotation principle to solve the question of widening interest, for example, a term of three years and none to serve more than two terms consecutively? It seems to me that participation creates more active interest than does anything else, and that anything that cuts down the interest of the trustee in the institution he serves might become a disservice to that institution."

What Is "Business" Board?

The term "business board" has various interpretations. If it is to be construed as a board devoting itself to hospital affairs in the broader sense of the term, all well and good. If, on the other hand, it implies occupation exclusively with the financial operation it is wrong in its conception.

The ideal solution to this problem would be the appointment of a small board, that is, one comprising no more than 15 members, each one of whom has been carefully selected for his or her individual contribution. This board should possess social as well as business attributes. It should reflect the community approach to public health, if we are to accept the definition of hospital service as a public utility—but a public utility conducted for service rather than for profit.

Like the board of the community chest it should represent all local interests, including various religious creeds and races, also labor, social agencies and philanthropies, as well as management, finance, commerce and industry. It should be a community board in the true sense of the term. Having achieved such desirable representation, if the same men and women happen to possess special skills so much the better. As advantageous as it may appear to appoint a clever engineer to the hospital board for services he may render, this qualification alone is not sufficient to warrant his inclusion among the directorate.

"While such representation may introduce more or less conflicting points of view into the board itself, it is one of the best insurances against conflicts arising between the institution and its community," states Dr. Warren P. Morrill, director of research, American Hospital Association.

"Even the most radical thinker, once he is faced by the responsibility of putting his words into acts, is likely to curb his radicalism. And the opportunity of venting his views behind the closed doors of the board room is quite likely to have a sobering effect.

"In the voluntary hospital that admits any considerable number of patients who as public charges receive care at the expense of tax funds, it is a wholesome practice to provide that the tax-spending agency concerned be invited to nominate at least one member of the board in order not only that the tax-spending agency may have a voice in governing the hospital but that it may have available firsthand knowledge of how the institution is conducted and the reasons therefore.

"Members should not be selected solely on the basis of their financial contributions to the hospital, their prominence in the community or their social standing. They should be selected on the basis of what they can and will add to the strength of the governing board.

Reflect Spirit of Community

"It may be necessary to include certain individuals solely on account of their prominence in the community and some groups in the community may demand recognition. The real strength of the institution, however, will rest on those trustees who can reflect the spirit of the community, who will take the time and make the effort necessary to familiarize themselves with the institution and its problems and who will exercise the same energy and acumen in solving its problems that they would devote to their own business or profession."

Fifteen has been suggested as the maximum number for a hospital board. This is assuming that an executive committee of five takes over the leadership. In arriving at any such decision local conditions must be considered. There may be any number of valid reasons why this figure should be reduced to seven or nine. Fewer good reasons will be found for increasing the number.

Among logical reasons for limiting the size of the board is that it encourages greater selectivity in admitting new members. We cannot afford to have any dead wood. Each

The needed step

When absorption is impaired by diarrhea, ulcerative colitis, or other gastrointestinal conditions, B-avitaminosis often ensues and oral therapy may always be just one step short of satisfying body needs. Parenteral administration of the required B complex factors in such circumstances may be life saving.[1] Solu-B,* intramuscularly or intravenously, is often the needed step to deliver high potencies and accurate dosage of the major crystalline B factors directly to avitaminotic tissues.

1. Int. Obst. Surg.; Supplement to Surg. Gynec. and Obstet.: 74:309 (April) 1942

SOLU-B In boxes of five (10 cc. size) vials, each vial accompanied by one 5 cc. ampoule sterile double distilled water; or in boxes of twenty-five (10 cc. size) vials without distilled water.

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individual must produce and assume his share of the responsibilities.

On the question of tenure of office there is little conflict of opinion. Widening interest and participation are essential, it is agreed. A three year term of service is common.

Doctor Morrill suggests staggered terms of such length that the newly appointed members will always be in the minority. This includes provision that one third of the membership shall be appointed each year and that the term of office shall be for three years. This ensures that at all times two thirds of the membership will have had at least one year's service. The advantages of such policy are, of course, continuity of planning, protection against attractive but unworkable proposals and general stability to the administrative program.

As Doctor Morrill points out, on the other hand, "Important as continuity and stability of policy are, there is always the possibility of the board's becoming static as a result of the too long service without change. A board continuing too long in office may develop a sense of proprietorship that tends to make it less responsive to newly developed community needs. And even if the board does not develop such a defect, the public is likely to develop a comparable attitude that the hospital is a responsibility of the board in which the various members of the community have little interest and no responsibility.

"Isolating itself from the community is one of the most dangerous defects that the hospital can develop. Likewise, service on the governing board develops in the individual a new perspective toward the health problems of the community. The more widely this educational process is distributed through the community, the stronger will be the community's support of the institution.

"Every member retired from the board will thereby become a focus for education of the public concerning its institution. As new health and welfare problems develop in the community, new leaders develop and the movement may be of such character as to justify or even require representation on the hospital board.

"Recognition of these conditions has led to many proposals for providing for the need for 'new blood' on the governing board. One common method has been simply to increase the size of the board even though this may in some instances require an amendment to the charter. If the board is already relatively small this procedure may provide the best solution, but such action should not be taken lightly. No charter is sacred or unchangeable; however, since it is the basic document upon which the entire organization rests, it should not be altered too frequently or without mature consideration.

"Another method that has been advocated is to put a definite limit on the period of time any member can serve on the board without interruption, or to adopt some other such formal regulations. This probably is better than no change at all but is subject to the defect that boards often develop certain strong and progressive leaders whose retirement from the board would be a serious loss.

"But even this hazard brings with it a twin hazard, degeneration into a 'one-man' board. When such a condition develops, the retirement of this leadership is often a serious handicap but is likely to be but a temporary loss and less dangerous in the long run than a too long continuance of one-man dominance.

"Regardless of the method by which the membership of the board is selected, it is a practical working fact that once appointed the membership is, to a marked extent, the master of its own destiny. Whether there shall be any changes in the membership will usually be determined directly or indirectly by the board itself. For this reason it is probably best for the board to adopt such a forced change simply as a general policy or 'gentlemen's agreement' which need not be enforced if circumstances indicate that it would be unwise."

Question of the Month

QUESTION: Would you please outline for me the major points that a hospital trustee should bear in mind in dealing with the problem of public relations in his hospital?—R.T.D.

ANSWER: Following are 16 suggestions that might well be seriously considered:

1. The importance of recognizing public relations on a parity with all other administrative departments of the hospital.
2. The importance of having a full-time public relations executive in the larger hospitals and a part-time executive in the smaller hospitals.
3. The definition of public relations talent.
4. The importance of discovering and employing a public relations man with original ideas, imagination and initiative.
5. The importance of obtaining the best talent for this purpose and also of paying an adequate salary.
6. The relation of the publicity program to such communal efforts as the theater (for dramatic values), the radio (for wider audiences) and the press (as an additional disseminating agent).
7. The importance of close contact between the board of trustees, the administration of the hospital and the public relations executive.
8. The need for a public relations committee on a parity with all other committees of the governing board.
9. The importance of selecting trustees who are public relations conscious and who not only will sympathize with the program but will actively encourage it.
10. The key position of the director of the hospital in such a program; the commanding position of the president of the hospital in such a program.
11. The importance of clearing all information having public relations value through the office of the director to the public relations executive for communal interpretation.
12. The importance of avoiding independent action in the field of public relations before consulting with the hospital public relations executive.
13. Methods of cultivating the large variety of news agencies in order to obtain the best possible hearing for the hospital.
14. The major activities of the public relations executive with emphasis on the annual report, radio broadcasts and house organs.
15. What can be learned from industry in the field of public relations.
16. The various philanthropic strata —how the public relations program can extend to each one of them.—E. M. B.

Pharmacy Law *and the Hospital Pharmacist*

SYLVESTER H. DRETZKA
Secretary, Wisconsin State Board of Pharmacy
Milwaukee

IT WAS only about 65 years ago that most state pharmacy boards were established by legislative act to control pharmacy and pharmacists for the protection of public health. Many of our present day laws are predicated on codes of ethics practiced several hundred years ago by our professional forebears.

We have come a long way since those professional ancestors set up the first regulations. Never before has the need for laws and a strict "hewing to the line" been greater than it is today. With the constant increase in highly potent synthetic medicinal compounds comes the need for additional regulation.

Charge Laxity in Sale of Drugs

Much has been written about the number of deaths attributed to the misuse of sulfa drugs in various parts of the country. In Milwaukee only recently, the so-called laxness of supervision of the sale of sulfa drugs was given prominence in our local papers. It was charged by a prominent physician that 15 deaths in our state in the last three years could be attributed to misuse of various sulfa drugs and that five of these were due to across-the-counter sales in drugstores without prescriptions.

Investigation by the state board of pharmacy never disclosed such laxness and I gave such a statement to the press.

Later the newspaper commented editorially laying the blame on a loose system of refilling prescriptions.

I again challenged that statement, for in Wisconsin, while we do not have a law paralleling that of the Federal Food and Drug Act, our pharmacists observe the following rules with respect to refills—a system first used in the drugstores of Washington, D. C., and approved by the Federal Food and Drug Administration.

1. A refill may be obtained twice provided the attending physician gives his approval.
2. This approval may be verbal but the particulars must be indicated on the back of the prescription.
3. When the patient makes a third request, he is to be sent back to the physician for reexamination, presumably for a blood test to ascertain the effect of the drug on the system, in addition to other examination phases.

At some time or other, every pharmacist has thought that the regulatory measures which are enforced to protect public health were thought up for the sole reason of annoying the pharmacists. That is not so! State boards of pharmacy are just as quick to defend and come to the aid of the pharmacist when he is unjustly accused as they are to criticize when he fails to maintain the high standards of the profession.

The fault lies to a great extent in the fact that too many pharmacists haven't a clear realization of just what the activities of the state boards embrace. Do you know, for instance, that if the medical staff interferes with your activities, and in any way hinders your strict adherence to the rules and regulations of pharmacy, if you report the matter to the state board of pharmacy the condition will be corrected without the staff knowing that you had voiced a complaint? This is to protect both the patient and the hospital.

A short time ago a pharmacist in a Wisconsin hospital reported to his pharmacy board that he did not have sufficient refrigeration equipment to protect his stock of biologicals properly and that repeated requests to the management brought no improvement. The board immediately made a routine call of inspection on the hospital pharmacy and reported to the hospital authorities that more refrigeration was required. New equipment was installed at once.

Board Is There to Help

Pharmacists need a new concept of the meaning of their state board in relation to their daily tasks. Had one unfortunate hospital pharmacist in Connecticut had the proper concept of the work of her board of pharmacy, she would not be living under the cloud of suspicion which now darkens her life. Here is her story.

The girl, a University of Michigan College of Pharmacy graduate, is the registered pharmacist in a 400 bed hospital of excellent repute. In addition to her regular duties as pharmacist, she was required to attend to other details that took her out of the pharmacy. She was assisted by a 60 year old nonprofessional "handy man." Dextrose was kept in a 5 pound earthenware jar. It is assumed that someone filled the dextrose jar with boric acid in error sometime previous to the tragedy.

From a paper presented at the Tri-State Hospital Assembly, 1944.

Between 10 and 11 o'clock in the morning while the pharmacist was required to work in the surgical appliance department, a call came from the nursery for dextrose. Someone placed the 5 pound dextrose jar in the wire basket, from which was prepared a 5 per cent dextrose in normal saline solution. This feeding solution was then placed in 4 ounce nursing bottles. A student nurse proceeded to feed the solution, which contained not dextrose but about 90 grains of boric acid to each 4 ounce bottle, to the infants, all of whom were only a few days old. Fourteen babies became ill; five died.

Combinations Are Common

The laws of pharmacy do not stipulate that a pharmacist may not have multiple duties. In fact, combination of duties may be an economically sound practice, particularly in small hospitals, but when it is necessary for the pharmacist to be out of the pharmacy at any time, then the pharmacy should be ordered locked and should remain locked until the pharmacist can again be on duty.

This case also brings up the thought of storage regulations. Nothing is said in the rules about what type of jar must be used for the storing of dextrose and boric acid; the requirements for both are the same: "Store in a well-closed container." We should always be alert to discover new ways to protect the public, and probably if the storage jar used had been transparent rather than opaque, it would have been discovered by the casual observation of the pharmacist that the white powder in the dextrose jar was certainly not dextrose.

You may think this Connecticut case is quite remote and that "it can't happen here." I wish you were right but, unfortunately, tragedies like that are happening all around us.

Two deaths occurred in a Detroit hospital a year or more ago. These were the result of injecting an overdose of a new drug. The court was critical not only of the manufacturer but also of the dispenser and the administration of the product. I recall a similar occurrence in a retail pharmacy of my acquaintance, where professional coverage had been inadequate. The pharmacist proprietor prided himself in having had a handy man about the store for more than fifteen years whom he regarded as being "as good as any pharmacist." A few years ago Jack, the handy man, was in the store alone and sold a soluble barium salt instead of the insoluble type used for x-ray purposes, and this mistake resulted in the death of a young business man.

Civil suit followed; the pharmacist-owner and the doctor paid dearly —not only in cash, but in sleepless nights, the sorrow of their own families and the families of Jack and the industrialist. Jack is no longer in the drugstore, neither is the young industrialist here to help win the war of industry. The physician, whom I also know, has never been quite the same.

"It can happen here!" Don't let it happen to you!

Don't delegate to nonprofessional, nonregistered helpers duties which you and others have worked hard for the professional privilege of assuming.

Report immediately any infringement or even apparent violations of the pharmacy laws and regulations to your state board of pharmacy.

Be articulate in seeking better and fuller legislation to protect the health of our nation.

Have the courage to make known your equipment needs.

The hospital pharmacist deals almost exclusively with professional people. Learn to speak authoritatively about your specialty, thereby improving the high standards of your chosen profession.

Familiarize yourself with the storage requirements for the drugs and chemicals you have in stock.

Keep always in your library at least the required volumes, including their supplements as they are released. Let the staff members and interns of your hospital know of the important material contained therein. Refer to them frequently and encourage these professional colleagues to make use of them. Don't limit your pharmacy only to those books required by law; extend your library and expand your knowledge.

Keep up your standards, setting the pace for other hospital pharmacists, and lead the way so that the standard of the retail pharmacy will be ever higher in order to cope with your advance.

By bettering hospital pharmacy you are bettering the profession as a whole.

Narcotics Are Booby Traps

J. R. McGIBONY, M.D.
Hospital Facilities Section, U. S. Public Health Service
Washington, D. C.

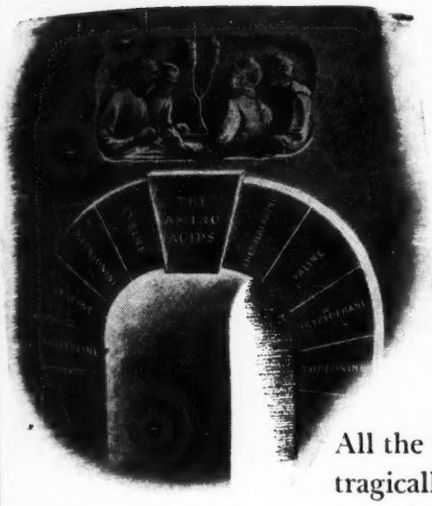
THE impact of the stress and tension of living in a war-torn world has produced a backwash of utmost seriousness affecting the health and efficiency of many individuals. And hospitals are in position to help control this unwelcome tide with a finger in the dike.

This is the distressing increase in the use of hypnotics, "sleeping pills," generally lumped together under the name of barbiturates. Their promiscuous use has resulted in tripling sales of such preparations since Hitler's march into Poland. It is estimated that more than 6,000,000 doses are used daily in the United States and the increase is so rapid that public officials are becoming seriously concerned with the possible necessity of federal legislative action.

Laxity of many hospitals in maintaining proper records and adequate safeguards over stock and ward supplies may make them thoughtless contributors to the development of habitual users, increasing that unfortunate number to which the unsavory term "addict" must be applied.

When properly used, hypnotics comprise one of the most valuable groups in the physician's armamentarium. They have a more or less specific depressing effect on the psychic faculties, inducing a condition closely resembling natural sleep.

Chloral, the first of these, was introduced in 1869, then paraldehyde in 1882, followed shortly by sulphonal, trional and several chlorine and bromine compounds. After the introduction of veronal in 1903, and



Vital Support in Modern Surgery

All the wealth of modern surgical skill and knowledge may be tragically unavailing if the patient is physically unfit for operation. In poorly nourished patients, preoperative correction of hypoproteinemia lessens surgical risk . . . hastens healing. Parenamine—clinically proved parenteral substitute for dietary protein—restores and maintains positive nitrogen balance . . . corrects hypoproteinemia . . . stimulates regeneration of tissue and serum proteins.

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AMINO ACIDS STEARNS PARENTERAL

For protein deficiency

PARENAMINE is a sterile 15 per cent solution of all the amino acids known to be essential for humans, derived by acid hydrolysis from casein and fortified with pure *dl*-tryptophane. Sterility, freedom from pyrogens, and standardization of each batch are meticulously checked by laboratory procedures, animal testing, and injection of full therapeutic doses clinically.

INDICATED in protein deficiencies and conditions of restricted intake, faulty absorption, increased need, or excessive loss of proteins. Particularly useful in preoperative and postoperative management, nephrotic toxemia of pregnancy, extensive burns, delayed healing, gastrointestinal disorders, cirrhosis, nephrosis, fevers, and other hypermetabolic states.

ADMINISTRATION may be intravenous, intrasternal or subcutaneous. Dosage may be estimated at 1 Gm. amino acids per kilogram of body weight per day, plus sufficient excess to correct the existing deficiency.

SUPPLIED as 15 per cent sterile solution in 100 cc. rubber-capped bottles.

Complete clinical information will be gladly sent on request.

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various other synthetic barbituric acid compounds around that period, the use of hypnotics gradually increased, serving a long-felt need. However, in recent years the types and numbers for sale with little if any restriction have sky-rocketed until today there are hundreds of preparations on the market. At least half of those consumed are purchased without prescription.

With judicious use as directed by a physician cognizant of potential ill effects, such drugs are indispensable. Yet they can be dangerous. Nevertheless, some physicians, nurses, hospital employes and others well versed in health matters are among those who use them too frequently without thought of effects other than for a bit of sleep, rest and surcease from the cares of strain and worry.

It can only be expected then that some people, subjected to incessant bombardment by radio and other advertising of a thousand and one ailments which they are encouraged to discover in their own anatomy and physiology by self-diagnosis, should seek that same surcease without knowledge and discrimination by the simple expedient of over-the-counter purchases.

Efforts Must Be United

Many reputable pharmacists realize the danger and refuse to condone such sales, but without concerted and unified effort the abuse cannot be controlled. Physicians should hesitate before authorizing the refilling of prescriptions without demonstrated need.

The strenuous life being led today by most Americans, with neuropathic tendencies always inherent in a race so mixed and intermarried and combining all degrees of emotional state, cannot but lead to conditions that require artificial stimulation and relaxation. The only alternative is education, direction of vitality along saner lines, proper working conditions and hours, and recreation. At the same time escape through dangerous and detrimental channels should be made as difficult as possible.

Hospitals have a definite responsibility in this scheme and the suggestion is made that stocks of hypnotics be kept under lock and dispensed with care little short of that required for narcotics. Don't leave a booby trap in the path of your staff.

Thiouracil in Hyperthyroidism

HAROLD F. CHASE, M.D.
Department of Pharmacology, Western Reserve University

IN 1941 Kennedy and Purves observed that rapeseed and its constituent, allyl thiourea, were goitrogenic. Shortly afterward the McKenzies published their observations concerning the hyperplasia of the thyroid gland produced by administration of certain sulfonamides in animals and this hyperplasia was shown to be similar to that resulting from thiourea in reference to histologic changes and resultant physiologic effects.

Astwood examined a series of compounds related to thiourea, aniline (sulfonamides) and cyanide. He showed that of all the substances tested 2-thiouracil was the most potent agent, and that a number of other derivatives of thiourea, including thiobarbiturates, were more effective than the parent agent. He confirmed the finding of the McKenzies that not only were the sulfonamides effective but also that the inhibitor of their antibacterial action, para-aminobenzoic acid, caused a similar hyperplasia, suggesting that the mechanism of their action upon thyroid hormonal function differed from that of their antibacterial activity.

Astwood postulated the working hypothesis that the aniline series acts through a competitive mechanism in the enzyme system responsible for conversion of di-iodotyrosine to thyroxin and that the thioureas are possibly inhibitors of the same system. More recently Campbell and his co-workers have suggested that the mode of action of thiouracil may be in its peculiar power to combine with iodine to form formamidine disulfide hydriodide, thus preventing the synthesis of di-iodotyrosine and hence of thyroxin.

There has been shown to be a decreased accumulation of radioactive iodine in the gland which is under the influence of thiouracil and also an increased excretion of iodine in the urine of such subjects. Cessation of the formation of thyroid hormone is believed to stimulate the thyrotrophic hormone of the pituitary, causing further hyperplasia of the thyroid gland which, however, does not overcome the thiouracil block to active thyroid hormone production.

Physiologic and Pharmacologic Effects. Thiouracil, when administered to animals or to human beings over a period of time, produces hyperplasia of the thyroid gland with increase in size of the columnar cells, disappearance of colloid and increased vascularity. With continued dosage the gland may sometimes decrease in size, though not in all patients.

Marked physiologic changes significant of diminished quantities of thyroid hormone accompany the anatomical changes. The basal metabolic rate is progressively decreased in human beings in the course of a few weeks and can be maintained at normal levels with reduced dosage. Symptoms and signs of hyperthyroidism, such as nervousness, tremors, palpitation, rapid pulse, thermophobia, muscular weakness, increased appetite, diarrhea and weight loss, are corrected at a rate roughly paralleling the return of the B.M.R. to normal levels.

However, exophthalmos tends to remain stationary or to increase except in a few reported cases in which it slowly regressed. Increased cardiac activity, pulse pressures and cardiac output have been shown to regress toward normal. There are a reduction in protein-bound iodine and an increased concentration of cholesterol in the blood.

Rapidly Absorbed and Excreted

Williams and co-workers have studied the absorption, distribution and excretion of thiouracil extensively in animals and in man. They have found that it is rapidly absorbed from the gastrointestinal tract and excreted in the urine. Daily doses of 0.2 to 1.2 grams in human beings resulted in levels of 0.8 to 6.4 mgm. per cent in the blood stream. Maintenance of a specific concentration of thiouracil in the blood did not seem necessary to achieve a desired effect, but the division of the daily total into several small doses seemed indicated.

Most of the drug in the blood was contained in the cellular constituents. When administered to moribund patients, it was found in greatest concentration in bone marrow, thyroid, ovaries and pituitary gland though it could be found in all tissues and body fluids. The concentration in breast milk was about three times that in the blood.

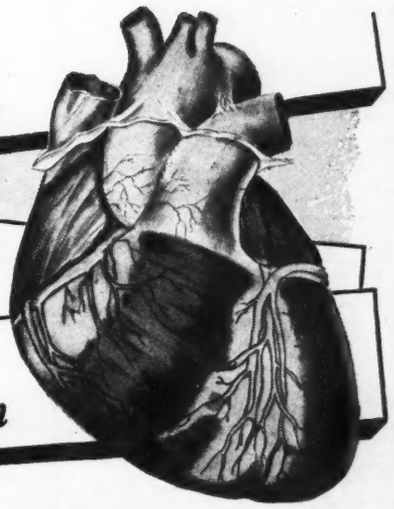
Therapeutic Applications. Astwood followed his preliminary studies in animals with clinical trial of thiouracil in a small series of patients and demonstrated its clinical effectiveness. In the short time intervening since, thiouracil has been given trial in many clinics on an experimental basis.

The usual procedure in the treatment of hyperthyroidism is to start the patient

The chief active glycoside of Digitalis purpurea...

as effective by mouth as by vein...

virtually free from nausea and vomiting due to local action



DIGITALINE NATIVELLE, the original, pioneer digitoxin, the chief active glycoside of Digitalis purpurea in pure, crystalline form, brings to digitalis therapy a notable efficacy and simplicity of dosage. It permits of effective, rapid, single-dose oral digitalization within 3 to 6 hours, with an "average dose" that almost never leads to nausea or vomiting from local irritant action.

NOTE THESE ADVANTAGES

1—*Potency:* Since it is the chief active glycoside of Digitalis purpurea, Digitaline Nativelle literally is digitalis freed from the inert material which in digitalis leaf preparations clings to the active substance.

Hence, weight for weight it is 1000 times as potent as U.S.P. XII digitalis when given orally, *one milligram* exerting approximately the same action as *one gram* of whole-leaf digitalis. This potency is constant, permitting of precise dosage by weight, instead of bio-assay "units."

2—*Absorption:* Digitaline Nativelle is absorbed quantitatively, probably directly from the stomach. Dosage is therefore the same whether given by mouth or by vein.

3—*Speedy Action:* There is no demonstrable difference in the speed with which its full action is exerted, whether it is administered orally or intravenously.

4—*Less Local Irritation:* The dosage required for initial digitalization is so small that nausea and vomiting from local irritant action are almost never encountered.

ACTION AND INDICATIONS

Since Digitaline Nativelle is the chief active glycoside of Digitalis purpurea, its action is that of digitalis. Hence it is indicated whenever digitalis is called for.

SINGLE-DOSE DIGITALIZATION

In urgent cases, it is recommended that the entire oral digitalizing dose —1.2 mg., established as "average" in more than a thousand consecutive unselected cases—be given at one time. Its full effect will be produced in 3 to 6 hours. In other cases, if preferred, this dosage may be given in divided amounts, over 12 to 24 hours.

MAINTENANCE

It is recommended that maintenance be instituted with 0.1 mg. (equivalent to 1½ gr. of digitalis leaf) daily, and increased if and as required.

Available on prescription through all pharmacies.

Digitaline Nativelle is reasonably priced, within reach of every patient.

ACCEPTED AMERICAN MEDICAL ASSN.
COUNCIL ACCEPTED

Physicians are invited to send for samples, literature, and bibliography.

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THE ORIGINAL DIGITOXIN, IN PURE CRYSTALLINE FORM

on divided doses of 0.6 to 1.0 grams daily for the first week or two and then to reduce the dosage as rapidly as possible to a maintenance dose of 0.1 to 0.3 grams per day, being guided by the clinical and metabolic response of the patient.

A normal metabolic rate has been achieved in such patients in periods of time varying from ten days to three months, depending upon the severity of the hyperthyroidism and the refractoriness of the disease. In preliminary reports it has been shown that patients can remain in remission for periods of from three to seven months when administration of thiouracil is discontinued, but that a high percentage of patients will have relapses and will respond again to the drug.

Most workers are in agreement with Rose and McConnell who conclude: "Thiouracil effectively controls most phenomena of thyrotoxicosis in the large majority of patients, and its present use is justified in the protracted treatment of mild and moderately severe cases and in the preoperative preparation of selected patients for thyroidectomy. It may also prove of value in patients regarded as unacceptable surgical risks."

Toxicity. Toxic reactions to thiouracil resemble those produced by the sulfonamides and seem mainly to be in the nature of "sensitivity reactions" which are unrelated to the dose or to the duration of therapy. Reactions to thiouracil have been reported as occurring in from 10 to as high as 30 per cent of patients in various series of cases reported. They include neutropenia sometimes associated with pharyngitis and fever (agranulocytosis), fever, morbilliform rash, allergic arthritis, myalgia, edema, vomiting and enlargement of the submaxillary salivary glands. Most reactions disappear on discontinuance of the drug and frequently treatment has been resumed after intermission with no reappearance of undersirable effects.

By far the most serious event is the occurrence of agranulocytosis which has already resulted in several deaths and is often refractory despite withdrawal of the drug and treatment with blood transfusions, pentnucleotide and liver injections. The use of folic acid has been suggested as a possible adjuvant in treating agranulocytosis.

Certainly, clinical use of the drug must be accompanied by frequent determinations of the leukocyte count and a warning to each patient to observe and report and close questioning of the patient concerning the first signs of pharyngitis and fever.

Conclusions. Thiouracil is a singularly effective drug for the treatment and control of hyperthyroidism, but because of its unpredictable toxicity its use should be controlled until satisfactory methods of preventing or controlling the toxic properties are discovered.

CLINICAL BRIEFS

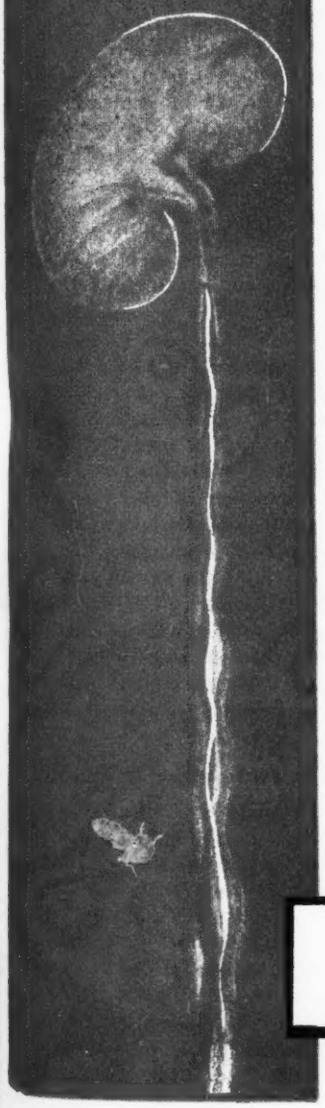
Conducted by E. M. Bluestone, M.D.

"No Smoking!"

In his article, "Smoking and Tuberculosis," which appears in the July 15 issue of the *New York State Journal of Medicine,* Dr. Herbert F. Schwartz states that he sent a questionnaire on this subject to 50 tuberculosis sanatorium directors. Their replies indicate that only 2 per cent felt that smoking was not harmful to tuberculous patients but only 16 per cent had rigid rules forbidding it. Most of the hospital heads permitted smoking in certain cases or ignored the fact that the rules were being broken. We are reminded that it is difficult to persuade patients to forego a definite pleasure and, usually, a habit of long standing, in return for a benefit which, to them, is of questionable value.

PREVENT DRUG-IMPACT

by Intramuscular Injection



It is no longer necessary to subject the decompensated heart to the sudden drug-impact of intravenous injection. Mercuhydrin administered intramuscularly is released to the circulation slowly instead of entering in massive concentration. The conduction centers of the heart thus are spared because of the gradual absorption from the intramuscular site. Moreover, there need be no fear of local reaction from intramuscular injection of Mercuhydrin . . . even when accidentally deposited subcutaneously, it has not caused serious tissue damage.

While it possesses definite advantage for intramuscular administration, Mercuhydrin also may be given intravenously with the usual assurance. By either route it has demonstrated outstanding diuretic efficiency both as to quantity of urine excreted and duration of effect.

LAKESIDE LABORATORIES, *Milwaukee 1, Wisconsin.*

Mercuhydrin is the sodium salt ot methoxyoximercuripropylsuccinylurea with theophylline. It is supplied in both 1 cc. and 2 cc. ampuls.

better tolerated locally

Mercuhydrin

The author also asserts that an examination of recent literature leads to the conclusion that, since smoking is harmful to normal people, it is bound to have a deleterious effect upon the respiratory tract of tuberculous patients, and that the best approach to the problem would be a hard and fast rule forbidding smoking, with frequent explanations about the dangers that may result from continuing to indulge in this habit.—JOHN F. CRANE.

Uses of Thiouracil

Various drugs that are harmful to the biological economy of man can yet be put to some beneficial purpose. A case in point is the use of the new thiouracil. In a brief paper by G. W. Bissell, "Thiouracil: A Review of Its Clinical Indications" which appeared in the *New York State Journal of Medicine,* Aug. 1, 1945, the value of thiouracil for the treatment of thyrotoxicosis is driven home. This disease is one that has baffled surgeons and physicians alike because the thyroid becomes overactive and produces more thyroid hormone (thyroxin) than the body can use with safety.

It was found that the use of sulfonamides and derivatives of thiourea, such as thiouracil, in normal animals induces hypometabolism with goiter, apparently because of the interference these substances offer to the production of thyroxin and the overstimulation of the pituitary gland. Harmful effects are induced by these drugs, especially thiouracil, because of its toxicity. Agranulocytosis, leukopenia, febrile reactions, cervical adenopathy, skin rashes, arthralgia and hematuria are known to occur after the use of thiouracil.

However, when the drug is applied clinically in the treatment of human thyrotoxicosis the ill effects of the disease soon disappear. The metabolic rate is reduced, weight is gained and the patient is restored to a clinically normal condition. The classical use of iodine for these conditions may be discontinued, for thiouracil replaces it because its action is sustained and progressive.

This article has one objective and that is to point out the conditions under which thiouracil may be used in thyrotoxicosis. The author lists these as: (1) uncomplicated severe hyperthyroidism in preoperative and postoperative stages; (2) recurrent thyrotoxicosis; (3) thyrotoxicosis which has not responded to iodine; (4) thyrocardiac, thyroid cachexia; (5) thyrotoxicosis associated with oculopathy; (6) thyrotoxicosis accompanying infections, especially tuberculosis; (7) thyrotoxicosis accompanying pregnancy, and (8) thyrotoxicosis in children.

On the other hand thiouracil is contraindicated in such conditions as (1) nontoxic goiters, (2) doubtful cases and (3) diseases which are associated with elevated metabolic rates, as in essential hypertension, leukemia and heart disease. Uncooperative patients and those with unbalanced personalities are poor risks for this type of treatment.

The nature of the drug used imposes strict supervision of the patient. An intelligent patient derives the most benefit from this treatment. The great drawback to the use of this antithyroid drug is its toxicity. The development of a substance that will possess the potency of thiouracil and the low toxicity of iodine is the next step toward the complete mastery of thyrotoxicosis.—MICHAEL LEVINE.

Sodium Amytal *vs.* Hypnosis

How to make a victim of an accident tell his tale of woe usually presents no difficulty to the questioner. However, the recall of forgotten or painful experience and conflicts, the reliving of emotionally traumatic experiences, the uncovering of faking and of conscious distortions of fact and the clarification of amnesic episodes are not easily elicited from individuals who have experienced these conditions. These persons resist all efforts to make them talk.

The subconscious mind fails to respond at will but acts when the conscious willful controls are suppressed.

The effectiveness of narcosis in revealing buried memories and conflicts has been long recognized. In a recent paper entitled: "Amytal Interview," Brig. Gen. W. Lee Hart, Col. F. G. Ebaugh and Capt. D. W Morgan (Am. Jour. of Med. Sci. **210** (1): 125-131, 1945) bring to the attention of the neuropsychiatrists the use of sodium amytal in preparing the battle fatigue patient, the hostile and resentful patient, the amnesia patient or the suspected thief to a suppressed mental status where he reveals hidden facts necessary to his restoration to normal conditions.

Practically all barbituates have been tried in clinics for the clarification of psychiatric problems. These authors believe the use of intravenous injections of from 4 to 15 gr. (¼ to 1 gm.) of sodium amytal dissolved in 30 to 40 ml. of distilled water is most effective. They caution that 7½ gr. of caffeine sodium benzoate should be on hand as an antidote. The method for conducting these subconscious patients through an interview after injection of amytal has led to the term "amytal interview."

The advantage of the amytal injection for interview over the use of hypnosis is obvious. The hypnotic technique cannot be readily acquired. Sodium amytal induces a milder form of diminished awareness. There is no "hangover" with this drug if sufficient caffeine sodium benzoate is given. Amytal permits an interview of a selective recall of action and discussion as with hypnosis.

To the reviewer this is an interesting method of experimentations in mental processes and its effectiveness as a means of diagnosis should prove to be of great value.—MICHAEL LEVINE.

Further Study on Demerol

Demerol, occasionally referred to as Dolantin, Dolantol, D-140, S-140, has been studied pharmacologically and chemically by F. F. Yonkman, P. H. Noth and H. H. Hecht in "Demerol: a New Synthetic Analgetic, Spasmolytic and Sedative Agent," I. Pharmacologic Studies, *Annals of Internal Medicine*, 21 O. S. 26 (1): 7-16, fig. 8, 1944. This substance, they contend, is an adequate substitute for morphine, in both acute and chronic cases. The chemical, pharmacological and biological properties of demerol are reported as determined by a series of studies on smooth muscles of animal and man.

The chemical formula of demerol as described by Schaumann indicates a relationship with atropine and morphine. The pharmacological action of demerol resembles atropine in the production of mydriasis, suppression of saliva and insulation of the heart, bronchi and intestine against vagal stimulation. It resembles papaverin in its spasmodic action. Its production of analgesia, sedation, euphoria and "side-effects" marks its resemblance to morphine. Toxicity studies on demerol by various means show this substance to have no injurious effects on animals.

The physiological effect of this drug was studied on strips of uterine muscle from virgin and nonvirgin guinea pigs. Demerol usually relaxed the segment which had been contracted by epinephrin, pitocrin or physostigmin. Demerol activates a flaccid, previously untreated strip of uterine muscle.

Intestine experiments conducted on six dogs showed that demerol depressed some phases of intestinal activity and especially segmentation. This phenomenon, the authors contend, indicated the use of the drug in the treatment of postoperative ileus and diarrhea. In 15 experiments only one evidenced stimulation after the use of demerol.

The authors conclude that demerol is a safe drug. It is readily absorbed after oral, subcutaneous or intramuscular administration producing analgesia and sedation.—MICHAEL LEVINE.

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'ANUSOL'* Hemorrhoidal Suppositories are available to hospitals at the unusually low price of $2.00 net for eight dozen (96) suppositories; in 32 individual dispensing boxes, each containing three suppositories, and with panel for directions on cover. Supplied to hospitals and institutions on direct order. Use form below, if desired.

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Orientation Course

builds better dietitians

GENEVIEVE GORMICAN NORTH
Educational Director of Dietetics, Michael Reese Hospital, Chicago

IN GENERAL, the aim of a hospital course for student dietitians is to present, at the end of a specified period, a certificate of accomplishment to a young woman who will be of benefit to the patient, who will be capable of cooperation with the administration and who will be able to guide and train employes. This young woman is expected to know the functions of a hospital and her relation as a dietitian to the hospital and to the community as a whole.

In the spring of 1944, we reviewed our previous methods of student education at Michael Reese Hospital, Chicago, and decided that by making some modifications we could more certainly accomplish these objectives. The changes involved redistributing the time allowed in the various units of the hospital, arranging closer correlation of the lecture, seminar and conference material with the practical application and, finally, inducting the student into the hospital world.

The course for student dietitians at Michael Reese Hospital is of fifty-two weeks' duration, the first two weeks of which will be discussed hereafter. For fifty of these weeks, the student is given both practical and theoretical training in the three branches of work that concern the dietary department:

1. *Administrative,* in the purchasing, storing and cooking of food for patients and personnel; in personnel management, and in menu writing and budget control.
2. *Medical,* in the scientific dieting of patients (hospital and clinic).
3. *Educational,* in the teaching of student nurses and student dietitians; in job instruction of employes, and in the education of patients in regard to their general nutrition and therapeutic diets.

The experience offered the student is so arranged that she will spend approximately the first half of her training period in units in which the medical and therapeutic angles are most important. The latter half of the period is spent in those units in which administrative problems are her chief concern.

Student dietitians at Michael Reese are given practice in the administrative, medical and educational aspects of their chosen profession. Above: Supervising the setting up of food carts. Right: A student learns to calculate diets.

The following is a title outline of the work covered during the first two weeks. It includes orientation and therapeutic lectures, seminars, conferences and periods of observation. In addition, approximately seven hours is allotted for the preparation of seminar material, and one day (the first) is devoted to settling into the quarters. This accounts, therefore, for two weeks of six eight-hour days.

FIRST TWO WEEKS

Orientation—Fifty Hours

History of Michael Reese Hospital and the dietary department: Purpose of internship; outline of the course.
Ration books; identification badges; income tax cards.
Deportment: House rules.
Organization and plan of the hospital: Map of buildings.
Tour of hospital dietary department.
Visit to medical library.
Clinic patient: Eligibility and plan of treatment at Mandel Clinic (lecture).
Tour of Mandel Clinic and food clinic.
Food habits of the various racial groups attending food clinic (lecture).
Michael Reese Hospital chart—Make-up and method of recording (conference).
Interpretation of, and student's place in, each unit of dietary department: Presented by the staff member in charge of each unit (with written instructions for students).
Attendance at class for student dietitians and nurses, conducted by senior student dietitian assigned to therapeutic diets.
Observation of student duties in various divisions of dietary department.
Michael Reese Hospital personnel practices (lecture).
Michael Reese Hospital personnel practices regarding service employes (lecture).
The duties of the hospital hostess (lecture).
Approach to the hospital patient (lecture).

Therapeutic—Thirty-One Hours

Lectures by Medical and Research Staff	*Seminars Medical and Diet Therapy*	*Conferences Planning Therapeutic Diets*
	Review of factors that influence digestion and metabolism.	Review of the adequate diet: child, adult.
Review of the physiology and functions of the endocrine glands.	A. Conditions characterized by increased metabolic rate.	High calorie, high protein, high vitamin diets, *and*
Management of tuberculous patients.	B. Tuberculosis.	Diets in tuberculosis.
Diabetes and the mechanics of coma.	Diabetes complicated by surgery, retinitis, pregnancy. Child diabetic.	Calculation of the diabetic diet.
Gastrointestinal disturbances.	Review of the physiology of the gastrointestinal tract.	
Present trends in the treatment of gastrointestinal disturbances.	Peptic and duodenal ulcer; Ulcerative colitis.	Gastrointestinal diets.
Medical and dietary treatment in gall bladder and liver diseases.		Low fat, high carbohydrate diets.
Anemia and leukemia.	Treatment of anemia.	Anti-anemia diets.
Physiology and functions of the kidney.		
Diseases of the kidney.	Treatment in nephritis and nephrosis.	Diets for nephritis and nephrosis.
Obesity.	Obese child and adult.	Planning low calorie diet.
Geriatrics.	Some considerations in feeding the aged.	
Parenteral nutrition: the role of amino acids and vitamins.		
Evaluation of dietary treatment in diseases of the joints.		
Psychosomatic influences on nutrition in fatigue and in gastrointestinal disturbances.		
Psychology of feeding.		
Psychological approach to the child on a therapeutic diet.		

The medical and research staffs, in addition to lecturing to the students, have given us the benefit of their advice in planning and correlating material. In this way, sound medical background is provided before planning the therapeutic diets.

The largest part, thirty hours, of the orientation period is spent in supervised observation.

This outline is that which was used for the summer class of 1945. While the broad plan will be continued, the distribution of time and the subjects treated will vary in accordance with the newer trends in medical and diet therapy, as well as with the performance of the students in the various dietary units of the hospital.

The courses for the last three classes of student dietitians have been conducted according to this plan. The results have been gratifying in a number of ways.

Patients have benefited because the student dietitians with whom they are in contact are better informed than previously. With this preparation, the students have been able to adjust rapidly to the work of the various units of the department. In general, the morale is higher, the mistakes are fewer and the caliber of work done, especially in the first few months, is improved.

Food for Thought

• A medical survey of "Nutrition in Newfoundland" is reported in a 32 page pamphlet being distributed in the U.S.A. by the food and nutrition board of the National Research Council, 2101 Constitution Avenue, Washington 25, D. C.

• "The Nutritive Value of Vegetables" is a 37 page pamphlet that has recently come from the nutritional research division of the Mellon Institute, University of Pittsburgh. It is available free to dietitians and extra copies are available from the H. J. Heinz Company, Pittsburgh 12, Pa.

• A bibliography on restaurant sanitation prepared by the sanitary engineering division and the milk and food section of the Federal Security Agency will be of assistance to dietitians. The health and education of food handlers, detergents and the washing and bacteriocidal treatment of dishes and utensils are covered in the reference list.

So We Changed to Cash Salaries

and found the idea both practical and desirable in our 150 bed hospital

ELMINA L. SNOW
Administrator
Cortland County Hospital Association
Cortland, N. Y.

HAVING all one's employes on a straight cash salary had always seemed an ideal arrangement, but far from practical for a 150 bed hospital in a small community.

However, along came the war and, with it, more married personnel, part-time workers, higher salaries and many more problems too numerous to mention.

It became more and more apparent as time went on that there was much restlessness and discontent and that hospital workers did not take into account the value of maintenance. Comparing their salaries with those of people in industry and commerce, they felt that they were receiving much less, although in many cases they were getting more meals at the hospital, free of charge, than were warranted by their hours of work.

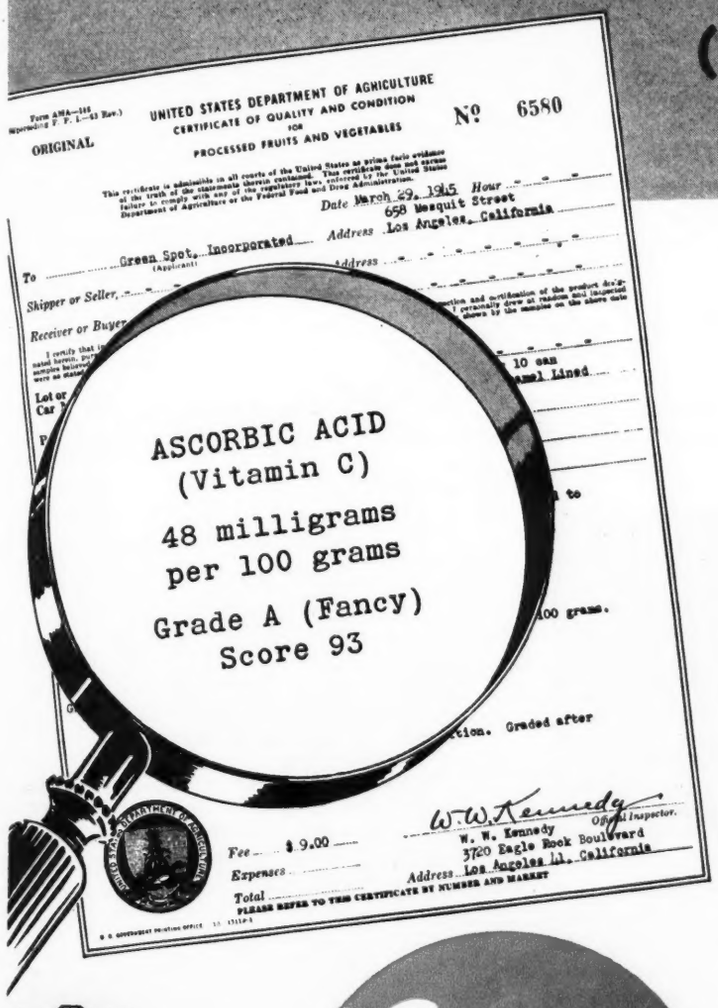
After long consideration we decided that many "gripes" from all departments would be eliminated if all workers were on a straight cash salary. To achieve this aim, it was necessary to convert from waitress service from the kitchen to cafeteria service, and with war-time restrictions on new equipment it seemed almost impossible.

The solution to this question at Cortland County Hospital, Cortland, N. Y., was simple. A serving table 84 by 40 inches, with two shelves underneath for dishes, was made by our carpenter. This was covered with linoleum and finished with a metal tray rail in front and space on top for taking care of all cold foods which are served for each meal. A small shelf back of the table accommodates a hot plate for tea and coffee and the electric toaster.

By using a steam table, which we already had and which is used also for serving patients' meals in the

The serving table, 80 by 40 inches, with two shelves underneath for dishes, was made by the hospital's carpenter. Behind the table is a small shelf that accommodates a hot plate for tea and coffee and electric toaster.

Fresh
NEAR-FREEZE
ORANGE JUICE
(Condensed)



Rushed to freeze room immediately after squeezing and condensing. Green Spot Orange Juice comes all the way to you under strict refrigeration—preserving natural flavor and high vitamin content achieved by extracting the juice of selected tree-ripened fruit within 24 hours of picking. One #10 tin plus ice cold water makes 5 gal. near-freeze, delicious orange juice at $1.07 per gal. (less in larger quantities) averaging 287 I.U. Vitamin C per fl. oz. (48 mg. per 100 g.).

JOBBERS EVERYWHERE TO SERVE YOU

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Quality confirmed by American Medical Association and U. S. Dept. of Agriculture

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CONDENSED ORANGE JUICE

(6 #10 tins per case)

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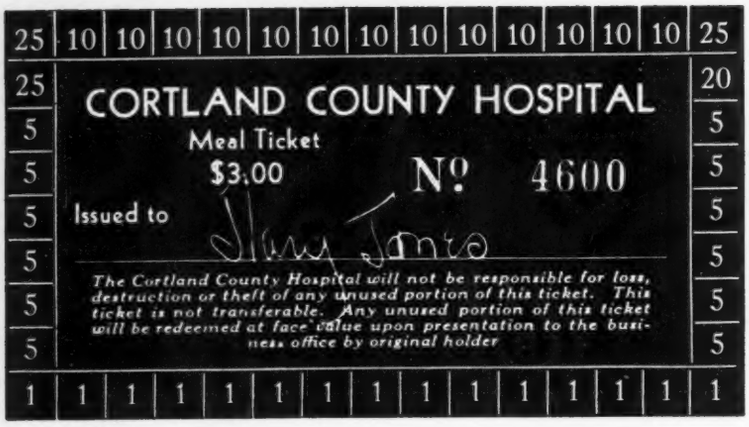


kitchen earlier, hot foods are kept hot for the entire meal period. This is wheeled in from the adjoining kitchen and placed alongside the serving table. By using this system, two maids, one serving and another punching meal tickets, can take care of the entire meal and we have a very satisfactory cafeteria with no expense beyond the serving table and a few trays.

With the inauguration of this service, we are able to have a choice of foods, which we did not have with the old system. This arrangement makes for economy, because we are able to use many left-overs and because the nurses order only what they want to eat. The dishes are priced individually and not per meal. When they have a choice, employes are able to get things they like, thus eliminating many complaints.

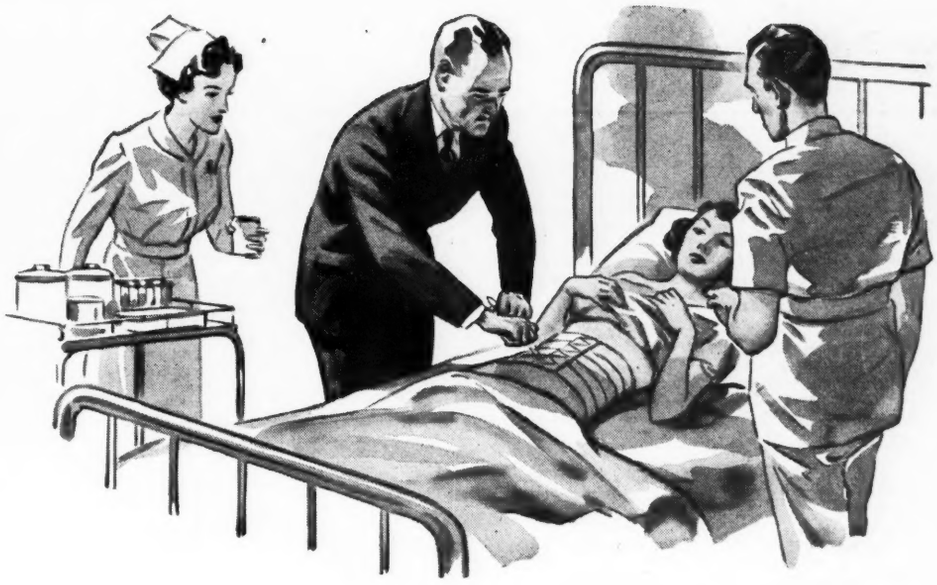
A ticket system, rather than cash, is used. Food tickets can be purchased in the business office for $3 and any amount not used will be refunded if the tickets are returned. No person will be served without a meal ticket.

Every hospital will probably arrive at a different figure in trying to determine cost of maintenance. For our needs we established $25 a month as the amount allowed for food and $10 a month for room rent. The latter amount is extremely low, even for this community, but we had many empty rooms in the nurses' home that we wanted to keep filled. On the other hand, we have allowed a larger margin for food than do some of the larger hospitals in this district.

Food Bills Dropped

In our hospital, and I believe this has been the experience of others, the food bills per year have dropped to an amazing degree. This is probably due to two causes: considerable reduction of waste and the fact that more employes have been eating out in off-duty hours, which we feel is also desirable.

Looking back, after two years of straight cash salaries, we feel that this has been one of the most satisfactory steps forward that we have made. It has brought about a much better understanding with the personnel, has eliminated many grievances and has provided a basis for an excellent public relations program.



Rich in Essential Nutrients

YET THOROUGHLY BLAND

Abdominal surgery, especially if resections, anastomoses, or colostomies are performed, usually calls for special dietary attention during convalescence and the entire hospital stay. Bowel activity must be avoided as much as possible to insure healing without deformities or other mishaps. In consequence, certain foods are interdicted, particularly those high in stimulating residue and fiber—fruits and vegetables. Yet these are the foods which supply many essential nutrients.

The usual postsurgical "soft" diet is significantly enhanced through the inclusion of three glassfuls of Ovaltine daily. This delicious food drink, made with milk as directed, provides virtually all essential nutrients in generous amounts. It readily converts the customary soft diet to one which is nutritionally adequate. Hence it favors a more rapid convalescence, encouraging speedier return of strength and well-being. The delicious taste of Ovaltine adds appeal to the diet, is relished by the patient, and encourages greater consumption of other foodstuffs.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three daily servings of Ovaltine, each made of ½ oz. Ovaltine and 8 oz. of whole milk,* provide:

PROTEIN	31.2 Gm.	VITAMIN A	2953 I.U.
CARBOHYDRATE	62.43 Gm.	VITAMIN D	480 I.U.
FAT	29 34 Gm.	THIAMINE	1.296 mg.
CALCIUM	1.104 Gm.	RIBOFLAVIN	1.278 mg.
PHOSPHORUS	.903 Gm.	NIACIN	7.0 mg.
IRON	11.94 mg.	COPPER	.5 mg.

*Based on average reported values for milk.

Menus for November 1945

Viola Foy
Piedmont Hospital
Atlanta, Ga.

1

Half Grapefruit
Scrambled Eggs
•
Creole Soup
Broiled Liver
String Beans
Carrot and Raisin Salad
Chocolate Pudding, Whipped Cream
•
Creamed Chipped Beef on Toast
Baked Potatoes
Broccoli
Applesauce

2

Sliced Oranges
Canadian Bacon
•
Vegetable Soup
Baked Halibut, Tartare Sauce
Mashed Potatoes
Spinach With Lemon
Lemon Pie
•
Cream of Mushroom Soup
Deviled Eggs
Hashed Brown Potatoes
Asparagus
Caramel Pudding

3

Apricot Sauce
Poached Eggs
•
Consommé
Potatoes in Cheese Sauce
Buttered Cabbage
Pickled Beets
Waldorf Salad
Boston Cream Pie
•
Breaded Oysters
Stuffed Potatoes
Sliced Tomatoes
Fruit Gelatin

4

Applesauce
French Toast, Jelly
•
Fruit Juice Cocktail
Baked Chicken
Dressing and Gravy
Green Peas
Celery, Olives
Ice Cream
•
Tomato Juice
Potato Chips
Olives, Pickles
Assorted Sandwiches
Oatmeal Cookies

5

Prunes
Scrambled Eggs
•
Chicken Noodle Soup
Roast Leg of Lamb, Mint Jelly
Mashed Potatoes
Lima Beans
Vanilla Pudding
•
Broiled Liver
Escalloped Onions
Buttered Carrots
Coleslaw
Brownies

6

Tangerines
Pancakes and Sirup
•
Baked Ham
French Fried Potatoes
String Beans
Stuffed Celery
Prune Whip
•
Chicken-Rice Soup
Escalloped Corn
Carrot-Pineapple Salad
Hot Rolls
Apple Betty

7

Cherries
Scrambled Eggs
•
Split Pea Soup
Swiss Steak
Rice With Gravy
Broccoli
Bavarian Cream
•
Chicken à la King in Patty Shells
Lima Beans
Head Lettuce Salad
Frozen Raspberries
Cookies

8

Applesauce
Cinnamon Toast
•
Tomato Soup
Meat Pie
Candied Yams
Green Asparagus-Lettuce Salad
Berry Cobbler
•
Cheese Soufflé
Green Peas
Vegetable Salad
Iced Cup Cakes

9

Bananas
Fried Eggs
•
Fruit Cup Cocktail
Red Snapper
Mashed Potatoes
Turnip Greens
Coconut Cream Pie
•
Oyster Stew
Baked Potatoes
Buttered Cauliflower
Fruit Gelatin

10

Grapes
Milk or Cream Toast
•
Vegetable Soup
Roast Beef
Browned Potatoes
Baked Squash
Pickle Relish
Bread Pudding
•
Cream of Pea Soup
Cold Meats
Assorted Mixed Pickles
Fruit Salad
Doughnuts

11

Half Grapefruit
Bacon
•
Noodle Soup
Fricassee of Chicken, Gravy
Mashed Potatoes
Broccoli
Celery, Olives
Ice Cream
•
Deviled Eggs
Potato Salad
Avocado, French Dressing
Chocolate Wafers

12

Tomato Juice
Omelet
•
Chicken Broth With Rice
Broiled Liver
Asparagus
Sliced Tomatoes
Boston Cream Pie
•
Tuna and Vegetable Casserole
String Beans
Celery, Olives
Cherry Pie

13

Prunes
Boiled Eggs
•
Vegetable Soup
Breaded Veal Chops
Harvard Beets
Green Peas
Banana Pudding
•
Cream of Mushroom Soup
Sliced Chicken Sandwich
Potato Chips
Baked Apples

14

Stewed Figs
Cheese Toast
•
Tomato Soup
Roast Lamb, Mint Jelly
Creamed New Potatoes
Summer Squash
Chef's Salad
Upside-Down Cake
•
Creamed Chicken on Toast
Buttered Grits
Combination Fruit Salad
Hot Biscuits, Jelly

15

Grapefruit Juice
French Toast, Jelly
•
Bouillon
Broiled Liver
Stewed Tomatoes
String Beans
Carrot-Raisin Salad
Chocolate Pudding, Marshmallow Sauce
•
Creamed Chipped Beef on Toast
Baked Potatoes
Broccoli
Applesauce

16

Sliced Oranges
Poached Eggs
•
Vegetable Soup
Fillet of Trout, Tartare Sauce
Mashed Potatoes
Green Peas
Lettuce Salad
Apple Pie
•
Creamed Ham on Toast
French Fried Potatoes
Steamed Cabbage
Fruit Cup

17

Apricot Sauce
Scrambled Eggs
•
Split Pea Soup
Roast Beef
Browned Potatoes
Glazed Carrots
Gingerbread, Lemon Sauce
•
Broiled Sweetbreads
Buttered Asparagus
Waldorf Salad
Coffee Cake

18

Bananas
Coffee Cake, Bacon
•
Mixed Fruit Juice Cocktail
Baked Chicken and Dressing
Candied Yams
Cauliflower, Hollandaise Sauce
Celery Hearts
Strawberry Shortcake
•
Fish Chowder, Crackers
Tomato-Cottage Cheese Salad
Assorted Cookies

19

Oatmeal With Raisins
Link Sausages
•
Tomato Soup
Macaroni and Cheese
String Beans
Corn Pudding
Fruit Cup, Spice Cake
•
Lamb Chops
Escalloped Potatoes
Buttered Beets
Orange Bavarian Cream

20

Baked Apples
Soft Boiled Eggs
•
Cream of Pea Soup
Roast Beef
Mashed Potatoes
Spinach With Sliced Egg
Tomato Salad
Caramel Pudding
•
Cream of Celery Soup
Toasted Cheese Sandwich
Potato Chips
Banana-Berry Salad
Canned Plums

21

Tangerines
Pancakes and Sirup
•
Tomato Juice
Breaded Veal Cutlet
Escalloped Potatoes
Carrots and Peas
Devil's Food Cake
•
Scrambled Eggs With Cheese
Buttered Grits
Combination Vegetable Salad
Hot Rolls, Grape Jam

22

Stewed Peaches
Scrambled Eggs
•
Bouillon
Roast Veal and Dressing
String Beans
Coleslaw
Gelatin, Whipped Cream
•
Corned Beef Hash
Broccoli
Waldorf Salad
Cup Cakes

23

Grapes
Cinnamon Toast
•
Vegetable Soup
Tuna Salad
Creamed Potatoes
Green Peas
Celery, Radishes
Gingerbread
•
Pork Chops
Glazed Apples
Grits
White Cherries, Cookies

24

Applesauce
Boiled Eggs
•
Roast Beef
Corn Pudding
Turnip Greens
Pickle Relish
Boston Cream Pie
•
Tomato Soup
Creamed Chipped Beef on Toast
Parslied Carrots
Lettuce Salad
Lime Ice

25

Sliced Bananas
Bacon
•
Half Grapefruit
Smothered Chicken
Parslied Potatoes
Peas With Mushrooms
Sliced Tomatoes
Ice Cream
•
Vegetable Soup
Deviled Eggs
Peach Pickles
Pimiento Cheese Sandwich
Brownies

26

Prunes
Hot Biscuits, Honey
•
Vegetable Soup
Stuffed Green Peppers
Big Hominy
String Beans
Applesauce, Cookies
•
Cream of Potato Soup
Cheese Soufflé
Tomato and Lettuce Salad
Baked Pears

27

Applesauce
Link Sausages
•
Chicken Broth With Rice
Swiss Steak
Broccoli
Candied Yams
Celery, Olives
Ice Cream
•
Cream of Tomato Soup
Baked Ham
Potato Chips
Assorted Sandwiches
Lemon Cookies

28

Orange Juice
Milk Toast
•
Cream of Pea Soup
Corn Pudding
Glazed Carrots
Lettuce-Tomato Salad
Frozen Plums
•
Roast Lamb
Grits
Peas
Hot Biscuits, Apple Butter

29

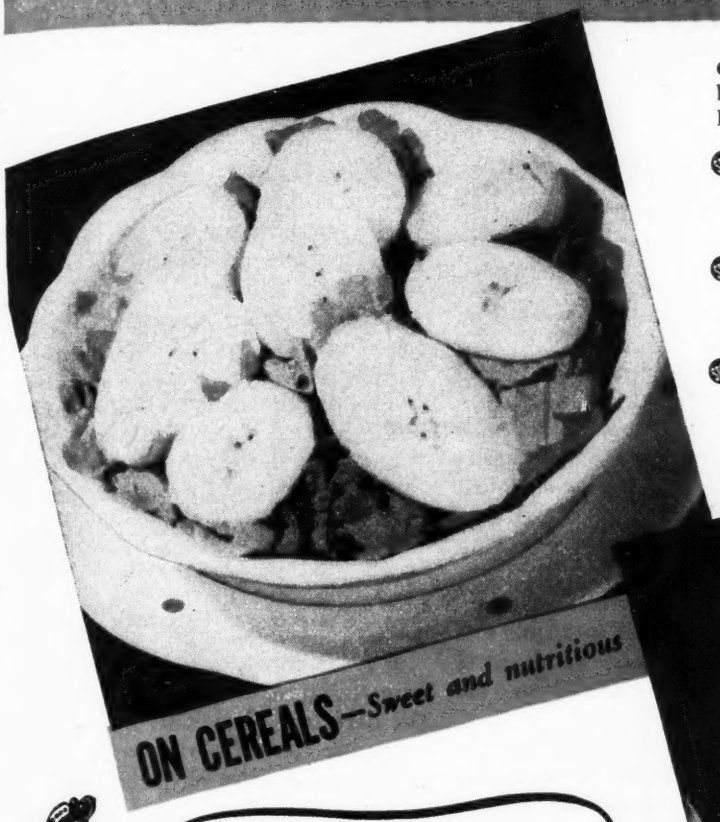
Half Grapefruit
Scrambled Eggs, Bacon
•
Tomato Juice Cooktail
Roast Turkey, Cranberry Sauce
Chestnut Dressing
Mashed Sweet Potatoes in Orange Peels
Parslied Cauliflower
Ice Cream
•
Oyster Stew, Crackers
Sliced Cheese
Baked Potatoes
Congealed Fruit Salad
Cookies

30

Sliced Oranges
Bacon
•
Chicken-Noodle Soup
Beef Stew
Baked Potatoes
Buttered Asparagus
Lettuce Salad
Cherry Cobbler
•
Cream of Corn Soup
Combination Fruit Salad
Avocado Pears
Cottage Cheese
Sliced Plain Cake

Ready-to-eat or cooked cereals are offered on all breakfast menus.

BANANAS...a natural sweetener



ON CEREALS—*Sweet and nutritious*

● One fully ripe banana (yellow peel, flecked with brown), average size, contains the equivalent of 5 level teaspoons granulated sugar—as follows:

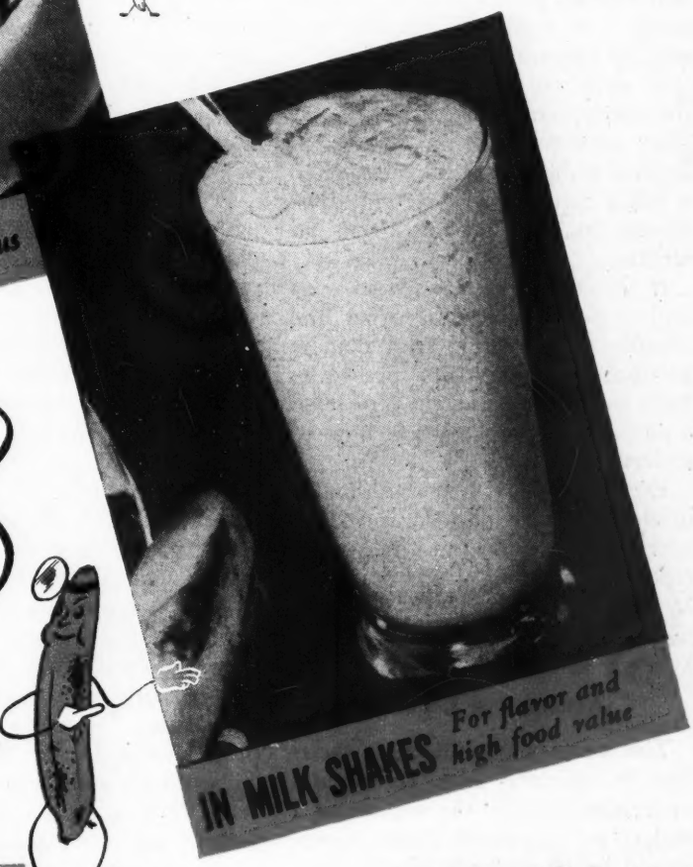
4.6% dextrose	Total sugars 20.4%
3.6% levulose	
12.2% sucrose	

PLUS

Vitamin A	310-420 International Units
Thiamin (B_1)	52-67 Micrograms
Riboflavin (G)	110 Micrograms
Niacin	.75 Milligrams
Ascorbic Acid (C)	12.5-13.7 Milligrams

PLUS

11 Essential Minerals	120 Calories



IN MILK SHAKES *For flavor and high food value*

1/2 OF 1 BANANA CONTAINS 2 1/2 TEASPOONS OF SUGAR

VITAMINS AND MINERALS, TOO!

ENJOY BANANAS AT THEIR BEST

DO	let them ripen at comfortable room temperature.
DON'T	put them in the refrigerator because this prevents proper ripening.
KNOW	that bananas are fully ripe when the golden peel is flecked with brown.

UNITED FRUIT COMPANY

Banana Milk Shake

(290 CALORIES)

1 fully ripe banana* **1 cup COLD milk**

**Use fully ripe banana . . . peel well flecked with brown*

Peel banana. Slice into a bowl and beat with electric mixer or rotary egg beater until smooth and creamy. Add milk and mix thoroughly. Serve COLD. Makes a 10 to 12 ounce drink.

NOTE: If electric drink mixer, which crushes fruit while mixing, is used, break banana into mixer cup, add milk and mix. Add ice cream before mixing, if desired.

Don't Poison Your Heating System

ERNEST C. WHITAKER
Consulting Engineer, Boston

THE hospital boiler plant and heating system constitute a department which effects no cures by itself but which is a necessity to the successful conduct of the entire hospital.

Its initial cost is some 10 to 15 per cent of the total cost of building construction, and the cost of maintenance varies greatly with its original design and installation and its subsequent operation.

It must be recognized, even by the mechanical personnel, that the plant is provided for the sake of the hospital rather than vice versa, yet it is still a part of the whole and must receive its share of intelligent attention.

If we are lucky enough to start with a new plant, it is easier and cheaper to keep it in trim than to perform periodic major operations upon it. If it becomes tired, or takes a day off or dies, the whole hospital suffers severely.

Even though a new building is needed or other equipment is deemed necessary, the plant must be kept in repair, for buildings and equipment are worthless if there is no steam for heating, hot water, sterilizers or kitchen.

Anticipating Repairs

The steam apparatus must therefore be operated with ability and understanding, and the wisdom of a budget for maintenance and repairs should be recognized. The maintenance cost may be held at a minimum if the budget is planned in advance on a long-time basis, as certain repairs are annual occurrences while others may be anticipated at five, ten or even thirty-five year periods.

Such minor chores as the packing of valves, flanges and steam pumps, preparation for annual boiler inspection and routine oiling of machinery may well be a part of the duties of the mechanical personnel, as may be also the checking and upkeep of radiator and other traps if properly understood.

The gradual wearing and maladjustment of reducing valves, gauges, regulators and automatic controls may usually be observed and repairs planned for the most convenient time, but repairs to such devices should really be made by the manufacturers.

Repairs and adjustments attempted by inexperienced or incapable mechanics almost always result in a greater expenditure or even the necessity of new equipment.

Stokers and oil burners should be inspected at least once a year, and necessary minor repairs and adjustments made. If this is done, major repairs should not be required for perhaps ten or fifteen years. Annual inspection of brick boiler settings will probably show the need of very minor upkeep every two years.

If this is conscientiously performed by boiler setting experts, continued high boiler efficiency may be maintained, and major repairs will be unnecessary for many years. With proper attention the efficient life of the settings should be at least twenty years. The necessity of retubing steel boilers may be expected after ten years, and complete boiler replacement in thirty-five years.

Budget Provision for Repairs

When these necessities are recognized, a sinking fund with annual allotments may be provided in the budget.

The prevention of the cause of repairs is fully as important as are repairs themselves. Overloading of boilers and other apparatus, the carrying of unnecessarily high pressures on heating systems, delay in making minor repairs, the use of inferior fuel, infrequent cleaning of boilers and tubes and poisoning of the boiler and system, all spell future trouble.

The poisoning of the system is so subtle, so little understood and yet withal so common and so destructive that a wider understanding of the subject is important.

The life and health of a boiler are constantly threatened from within and without, that is, from both the water side and the fire side. The use of good fuel and the maintenance of clean furnaces and tubes will reduce the external danger to a minimum.

Watch for Sabotage

It is the enemy within which concerns us most, because he works in the dark, and the results of his sabotage are too often discovered only after great damage has been done.

It is common knowledge that clean water makes steam more readily than does water containing dirt or oil, and an honest attempt is usually made to keep the boiler free from such impurities. On the other hand, the nature of the water supply varies with different communities and again between public and private supply.

Some waters are highly active in the raw state while others become so upon being heated. Even a reasonably neutral water may become corrosive after being in the heating system for some time. The two principal dangers are corrosion and incrustation or scale, although foaming and priming are factors which must be given consideration. When the latter actions are due to dirty water or undersized boilers, the trouble may be readily discerned and corrected; when due to improper type or quantity of boiler compound, it may not be so quickly discovered.

Incrustation and acid corrosion are commonly present at the same time. The acid condition may extend throughout the system; the incrustation will be most evident in the plant

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and will tend greatly to reduce the steaming capacity of the boilers. Water treatment must take all factors into consideration.

The cure for the disease is usually beyond the ability of the operating engineer, whose experience is mostly mechanical and limited to one community. To make matters worse, he may innocently place his case in the hands of one of the several witch doctors whose only interest is in the sale of the greatest quantity of the most profitable and secret merchandise. The result has frequently been the poisoning of not only the boiler but the entire heating system, as evidenced by the following case histories.

In one lake shore institution, the boilers and feed water heater continually became incrusted with scale in spite of heavy doses of boiler compound, and return pipes failed in a few years. In the course of search for the trouble there were discovered 350 barrels of boiler compound stored in the cellar. Nobody seemed to know how it had accumulated, nor how much had been fed into the boilers.

An eastern hospital using a private water supply heavily dosed with boiler compound soon found the economizer clogged, the boilers bagged and reduced to almost 50 per cent of their efficiency and numerous leaks in valves and regulators.

At another eastern institution a dangerous leak was found in the main steam line upon which the entire plant depended, and the cause was attributed to unprotected expansion. Examination showed a whitish exudation at some pipe joints, boiler water columns severely clogged, gauges ruined and one boiler practically destroyed after seventeen years of service.

The engineer of a large college group was greatly perturbed by failures of steel, wrought iron, wrought and cast brass and copper, the failures appearing first in the heating systems of his newer buildings.

Examination showed an excess quantity of improper compound, which carried over with the steam. Age had provided a protective coating on the inside of the older piping, but this, too, was beginning to show signs of attack. An antidotal compound was substituted but, needless to say, it did not repair the already damaged materials.

These systems were all poisoned, either by the nature of the compound or by excessive dosage.

It is not intended to imply that all heating failures are due to boiler compounds, that their use should be forbidden or that all compound dealers are unscrupulous. The use of compounds, softeners, deaerators and other agencies is standard and correct practice, but the methods to be pursued and the quantities of compound should be intelligently decided upon only after exhaustive study and with consideration for the entire system rather than for a part thereof.

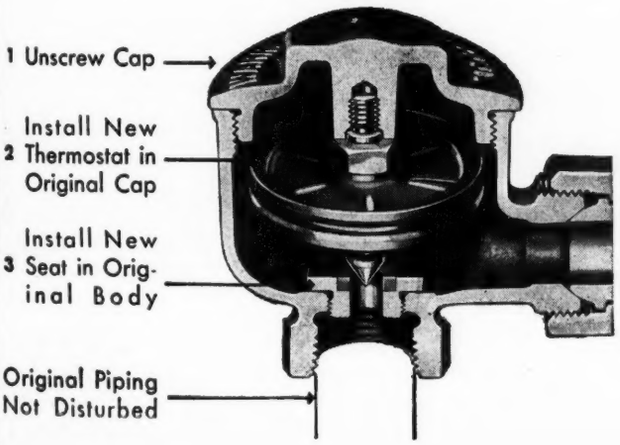
A disinterested consultant or plant engineer having wide experience with different plants and water supplies should be called upon at the first symptom of trouble. Conditions should be carefully studied, defective materials examined and tests made of raw, boiler and condensate water. If after such study the answer is in doubt, which often is the case, he must call into consultation a chemist experienced in analysis of the water and its effect upon the several materials involved.

STOP STEAM WASTE

The time to inspect your heating system is *now*, before coldest weather sets in. Replace *immediately* all parts that are wornout or operated inefficiently. (Remember, equipment that could have been delivered overnight in previous years takes more time now.)

The wise man checks each radiator trap regularly — looking for causes of steam waste; looking for dirt scale on trap seat opening; looking for valves and seats nicked or worn excessively on one side; looking for trap thermostats worn out by long use or excessive pressures.

It is easy to repair Webster Traps—right on the job. No need to disturb piping connections. Here's what to do:



Remove cap with monkey or cap wrench. Install new seat. Screw new Webster Trap Attachment into original cap after inoperative assembly has been removed . . . We furnish written instructions and will lend the installer any special tools required.

The properly operating radiator trap holds steam in the radiator until it has given up *all* of its useful heat . . . insures against any waste of "live" steam and loss of valuable fuel.

We will be pleased to help you correct the causes of steam waste in your heating system. Consult the telephone book for the address of the nearest Webster Representative. Or write us direct for General Catalog. Address Dept. MH-10.

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The Lobby Had Its Face Lifted

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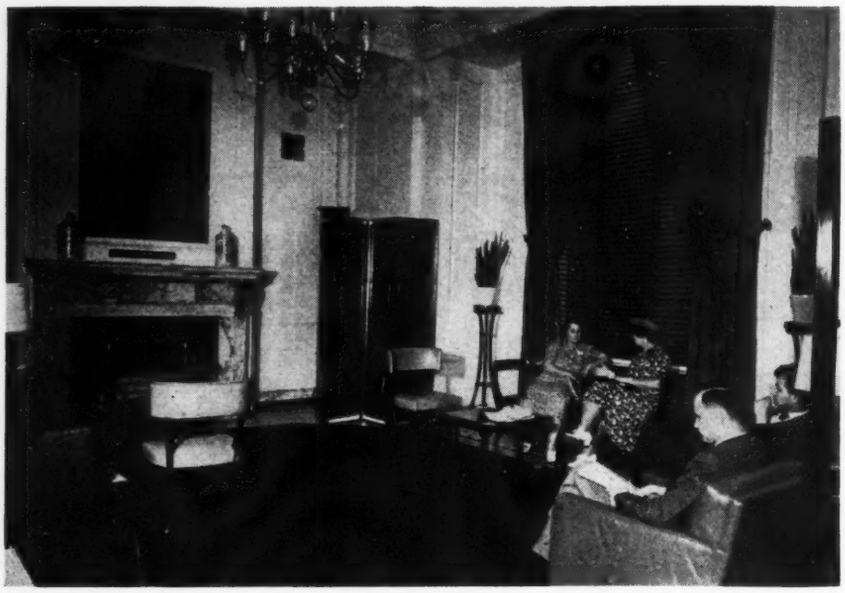

Comfort and color combine to make the lobby un-institutional.

HAD I for a moment imagined that I was elected to the woman's board of St. Luke's Hospital in Chicago for my wit, charm or executive ability, I should have been quickly disillusioned. At once I saw that it was purely because I am a decorator. These astute ladies thought it was a clever way to get my professional advice free.

If I was a bit hurt by this discovery at first—as indeed I was—I have since been most grateful, as it led to ten years of absorbingly interesting work as co-chairman of our furnishing committee, in cooperation with Mrs. I. Newton Perry. This has become our favorite charity work and is as engrossing as having a sick child on our hands.

An old hospital offers constant problems and makes endless demands on our time, tact, ingenuity and imagination. We have veritable congeries of buildings, dating from about 1882 on to the Schweppe Building of the School of Nursing. They are always being remodeled, departments are moved and new ones are added, and we are on the "inside" of all these jobs. In fact, we have now been appointed officially by the board of trustees and no new coloring or changes of furnishing are supposed to be made without our approval.

We find that our work falls into four departments: (1) patients' rooms; (2) technical rooms, such as laboratories and operating rooms; (3) living quarters for nurses and interns, and (4) public rooms, lobbies, reception rooms and offices of all types.

Our first major operation was on the lobby of our private pavilion, the Michigan Avenue building. Built soon after 1900, it was lofty and drab and very, very institutional! A patient, on entering, was confronted by a huge board covered with charts behind the reception desk, a depressing sight. So when one day, Charles H. Schweppe, the late president of the board of trustees, said, "If I gave you two women $5000 where would it do the most good?" we at once exclaimed, "the Michigan Avenue lobby."

We were convinced that it was important that the first impression made on an in-coming patient be in the new feeling we were trying to create in St. Luke's. We wished to obliterate all atmosphere of a hospital in this entrance, to make it look like an attractive club or residential hotel.

It was heavy and pretentious, so we knocked off all possible plaster ornaments on the paneling and ceiling. We concealed the charts behind a curved partition about 8 feet high that is built of wood lacquered black with gold lines, surmounted by a clock and pierced by a nail-studded red leather door giving access to the charts. The face of the long reception desk was also covered with the red leather, padded and divided into squares by brass nail-heads.

To give comfortable reception rooms on either side of the front door, we ran screens of wood, paneled above with small panes of glass, out at right angles from the entrance door. These directed "traffic" to the desk and gave a sense of shelter, almost of coziness, to the spaces behind them.

The walls and ceiling were painted a clear white, the doors a shiny black. Luckily, the floor was of tiny white tiles with a border of a Greek key in black. The two large high windows were given white venetian blinds with black tapes and full curtains of a brilliant scarlet which repeats the color of the leather around the reception desk. We used the same leather on several comfortable sofas and English club chairs. All low tables for lamps and smoking things are marbleized black.

On either side of the window are pedestals of a Regency design in black and gold to hold large sansevierias, silhouetted against the white walls. Octagonal black carpets

hold these two "rooms" together yet do not extend into the general passageway. A large mirror runs from behind one sofa to the ceiling, reflecting the mantel at the far end, surmounted by a portrait of the donor of the building.

Two enormous old pharmacy jars are in perfect scale on the mantel. Three severely plain brass chandeliers break the length but are seldom used as the lobby is lighted in an adequate, soft and home-like way by eight black and brass lamps with simple white shades. Two of these stand on the reception desk giving it a pleasant and inviting air.

And is this lobby used? Indeed it is, twenty-four hours a day! We find that the doctors like to hold their consultations with the families of their patients here. The sofas and easy chairs seem always full. Patients arriving, some nervous and worried, feel reassured by the atmosphere of cheer and comfort.

"You don't feel as if it were a hospital at all" is the remark frequently heard from patients and, dreading an institution, it is their idea of high praise.

Forgive this detailed description, but it is given to show what we are doing to modernize old buildings and this lobby has been an outstandingly succesful undertaking. Later, a new medical library was given to the hospital and our architect, Carl A. Erikson, has done a most beautiful paneled room in dark walnut of excellent modern design.

Finding that doctors are strangely like other men, who like any color so long as it is red, we have put in curtains and deep leather chairs of crimson. Three long study tables were made of the same wood and sturdy Bank of England chairs, impervious to the hard wear given by the interns, surround them.

Recently, we moved our director and our medical director into convenient but inadequate rooms, awaiting the erection of a new administration building. These offices are far too high for their size and face a dingy alley, so that they presented a problem.

They are separated by, and entered from, an office for their secretaries, which serves also as a waiting room. This is painted a clean sharp yellow with shiny black doors and woodwork, a white ceiling and white venetian blinds.

The private offices have walls of a deep rich Empire green, the tone of the beautiful drawing room in the Raleigh Tavern in Williamsburg, Va., a wonderful background for a masculine room. Long curtains of yellow with a modern design in the green with splashes of lacquer red make one forget the liability of poor proportions and lack of outlook.

We always consult carefully each person whose office we redecorate so that the coloring will be sympathetic. Obliged to use all the delicate pastel tones in patients' rooms, we have stressed the sharper colors in the public rooms, so as to counteract a certain anemic effect when only pale tints are used in a large building.

We also feel that the contrast of brilliant and gay colors has a valuable psychological effect on the doctors, interns and nurses. Unconsciously they are cheered by them and lifted out of the depression that a constant association with pain and tragedy must bring. So many long hours of their lives are of necessity passed within the walls of our hospital that it seems to us important that these walls should offer as much variety and stimulus and pleasure as possible.

Housekeeping in the Curriculum

If a student nurse is taught early to realize the importance of the housekeeping department in the hospital organization, its scope and the tremendous cost of running it, she will probably develop a spirit of cooperation with the housekeeping department and acquire at least a measure of respect for the value of the equipment and supplies which she is constantly using.

This is the hope of Jessie L. Wilson, executive housekeeper of Bradford Hospital, Bradford, Pa., who is testing out her theory by instituting a class in housekeeping for freshman students at her hospital.

There are so many phases of housekeeping and it is of such importance to the welfare of the patients that Miss Wilson is convinced that a study of it will prove not only interesting to students but quite valuable to them as they pursue their careers.

Miss Wilson is teaching the course herself, giving an hour's instruction once a week for a period of one or two months as the nursing department requests.

In the course of her teaching Miss Wilson hopes to demonstrate to her students the cost of the damage that results from careless spillage of medicines on floors, walls and linens; the unnecessary harm wrought to linens by pinning signal cords to sheets or pillow cases, and the virtue of letting the housekeeper know at once when an accident does occur so that the damage can be repaired early.

In addition to the lectures, Miss Wilson is planning an extracurricular project for which special credit will be given. This is to have such students as are interested construct various rooms in miniature, equipping them with doll-sized furniture and making draperies and linens. Another of her plans is to assign to each student a research project, such as compiling information on the history of blankets or linens.

Much of this material can be collected in scrapbooks, together with manufacturers' samples of the various materials.

At the end of the class, the miniature rooms and the scrapbooks will be placed on exhibit in a downtown shop window during hospital week.

It is surprising, says Miss Wilson, what clever creations a student nurse can turn out when she puts her mind to it.

Repairing Screens

The Army medical department has come up with its own method of repairing holes in screens that is much simpler and more rapid than the usual time-consuming method of sewing on a patch with copper wire.

Lt. Col. F. H. Stover, Sn.C., in the June 1944 issue of the medical department *Bulletin,* suggested the following technic:

With scissors or other sharp instrument, cut a square patch of new wire screening about twice the size of the hole to be repaired. Unravel and pull completely out of the mesh three or four strands of wire from each side of the patch; then turn the fringe (the free ends of the patch) up perpendicular to the sides of the patch, which will then bear some resemblance to a shallow tray.

Now turn the patch over and place it on the hole in the screen and with a hammer, or any object except your hand, pound the patch down over the hole. The free loose ends thus become enmeshed in the screen under repair and securely fasten the patch over the hole.

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4. *High light reflection longer — better light diffusion.* Satin-smooth finish — no harsh glare. Easier on the eyes.

Cut maintenance costs — and have exceptionally fine-appearing walls with Johnson's new Wax-Fortified Interior Finish. This patented finish (which will be available in white and a variety of colors) is impregnated with evenly distributed wax — to give your walls a lustrous, satin-smooth surface with great dirt and wear resistance. It's amazingly easy to clean, too.

Simple to apply

No special preparation is necessary. And, as for application — you'll find it handles easier than ordinary paints because of the lubricating power of the wax. Also it gives broad coverage with great hiding power for marred surfaces—a true economy feature.

No repainting worries

When it finally becomes necessary to repaint, no special cleaning is required. The new coat of Johnson's Wax-Fortified Interior Finish or of regular paint will adhere easily — for the wax in no way interferes.

The versatility and special advantages of Johnson's Wax-Fortified Interior Finish make it uniquely suited to the needs of schools, hospitals, restaurants, food plants, bakeries, dairies, factories, office buildings and department stores. Complete information is yours for the asking — fill out and mail the coupon today!

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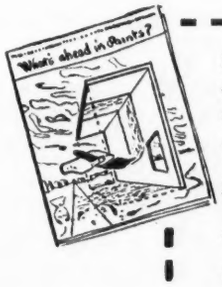

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NEWS IN REVIEW

Army Speeds Discharge of Doctors and Nurses; 14,000 Out by Christmas

WASHINGTON, D. C.—Approximately 14,000 doctors will have been released from the Army Medical Corps by Christmas under the Army's greatly accelerated discharge program, Brig. Gen. Raymond W. Bliss, acting surgeon general, revealed in testimony before the House Military Affairs Committee.

By Christmas also, said General Bliss, 25,000 nurses will be out of the Army Nurse Corps and 3500 dentists will be out of the Army Dental Corps.

Under the most recently announced Medical Department demobilization policy, medical and dental corps officers are eligible for release provided they meet any one of the following criteria:

1. Have adjusted service score of 80 or above.
2. Are 48 years of age to the nearest birthday or above.
3. Entered on active duty prior to Pearl Harbor, except for critical specialists qualified in eye, ear, nose and throat, plastic surgery, neuropsychiatry or laboratory clinicians. Officers qualified in these specialties are eligible for release if they entered on active duty prior to Jan. 1, 1941, or if they meet the criteria on points or age.

Only Army doctors who have not yet been overseas will be given assignment in foreign theaters, Surgeon General Kirk has announced. The same plan will be followed with reference to dentists, nurses and other officers of the Medical Department.

There will also be an age limit for overseas assignment, ranging from a maximum of 40 years for doctors and dentists to 30 years for nurses, dietitians and physical therapists.

The only enlisted personnel with the requisite number of critical points that will be kept are orthopedic mechanics, electroencephalographers who operate electrocardiac equipment and radio transmitter attendants. The last named are not in the medical department.

Nurses Top War Volunteers

Nearly 43 per cent of all active professional nurses in the United States volunteered for active war service or were certified for service by the Army and Navy, according to the *American Journal of Nursing*. More than 76,000 saw active duty with the armed forces. Those who remained at home took on a greatly increased load.

National Office Enrolls 22,000; Chicago Plan Contract Is Approved

The first national organization to enroll its employes through the National Blue Cross Enrollment Office in New York City is the American Woolen Company which is providing hospitalization for 22,000 employes. The company is paying the entire cost of the service for its employes.

After considerable dickering the Chicago Plan for Hospital Care was able to adopt on October 1 a new contract with broadened benefits and with the support of all 83 member hospitals. It will probably take six months for the plan to convert all of its present 800,000 members to the new contract, according to John R. Mannix, executive director of the plan.

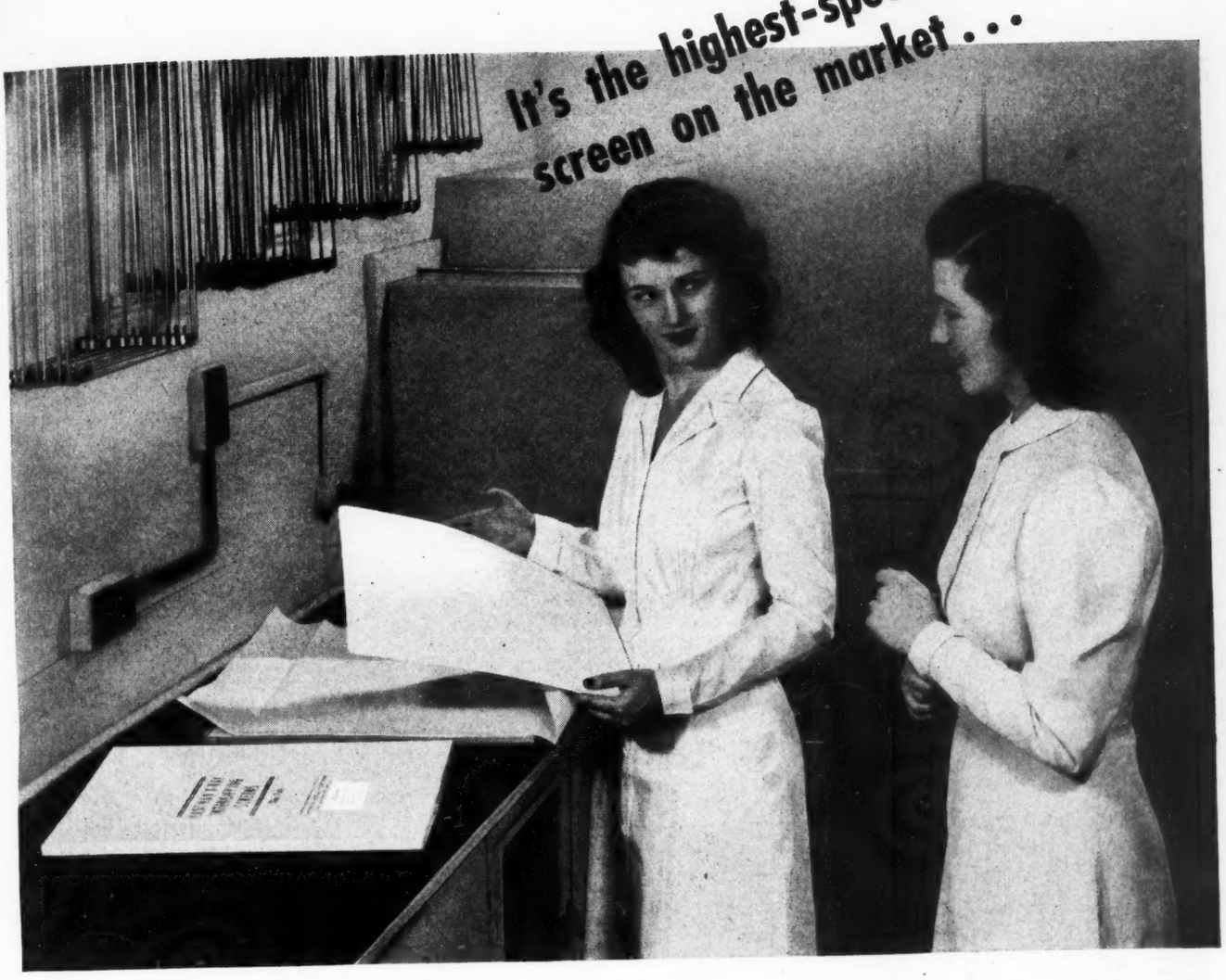
The new contract provides thirty days at full coverage (instead of twenty-one) and ninety days at half coverage. It adds x-ray, physical and oxygen therapy and all special drugs. For patients choosing private rooms, the allowance is upped from $4.50 to $5 per day. Diagnostic cases requiring bed care will now be included. Communicable diseases, tuberculosis and nervous and mental cases are covered.

Maternity cases can benefit after a nine months' waiting period instead of twelve months and without any waiting period if 75 per cent of the employes enroll. Service benefits (instead of cash benefits) are provided in reciprocating plans.

Premium rates for single persons remain at 80 cents per month and for families, at $2 per month. The two person contract, however, is to be eliminated.

Hospitals will be paid at the rate of 97 per cent of their billings up to a maximum of $8.50 per day. If their billings exceed this figure they will receive either 97 per cent of billings or 110 per cent of cost (excluding depreciation and interest on debt), whichever is lower. The additional 10 per cent over cost is to compensate for depreciation on buildings and equipment and for interest, if any is paid.

The Philadelphia Hospital Association recently requested the Associated Hospital Service of Philadelphia for an immediate increase of 50 cents a day for each day of full coverage under the existing contract with member hospitals without increasing benefits to subscribers. It further requested the Blue Cross plan to appoint a committee to act with its own committee in developing a more equitable method of payment.



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EASTMAN KODAK COMPANY, *Medical Division*, Rochester 4, N.Y.

"Time" Employes Are First to Subscribe to N. Y. Medical Service

A total of 981 employes of Time, Inc., became the first group to enroll in the new plan of the United Medical Service of New York City, according to an announcement made recently by Frank Van Dyk. The employer is paying the entire cost of premiums for all those employes who are now enrolled in Associated Hospital Service of New York. Similar privileges are available for 253 other employes on vacation, leave of absence or in military service.

The new plan of United Medical Service provides complete medical, surgical and obstetric care for individuals with annual earnings up to $1800 and families with not more than $2500 annual income. Subscribers with higher incomes may be billed by their physicians for additional fees. Premiums have been set at $1.60 a month for individuals and $4 a month for families.

The new plan was announced on September 14 and will be limited for a trial period to 25,000 subscribers. It includes service in the patient's home or the doctor's office, although physicians are permitted to charge not over $2 for night home calls to patients who are below the income limits.

More than 8000 physicians are cooperating in the United Medical Service program.

Nursing Council Votes to Continue Its Work

The National Nursing Council for War Service voted recently to ask the boards of directors of its 14 member agencies to continue the council until the "committee to study the national professional nursing organizations with regard to organization, structure, administration, functions and facilities" has made its report and the plan it proposes has been approved and is ready to function.

The council will continue to be the administrative unit for the National Nursing Planning Committee, handling its funds and helping to launch the projects outlined in its program for action.

Other immediate tasks of the council include cooperation in the current recruitment of nursing and other personnel for hospitals, helping the Veterans Administration and the Marine hospitals to obtain additional nurses and organizing a national student recruitment program to replace the work done by the U. S. Cadet Nurse Corps. A new committee was authorized to study the social implications for federal aid to nursing education, with a view to deciding what should be requested in the future.

Continue Campaign to Recruit 130,000 Hospital Employes

WASHINGTON, D. C.—The campaign to recruit 130,000 needed personnel for civilian and veterans' hospitals all over the country was carried on during September.

Sponsoring the drive were the U. S. Public Health Service, War Manpower Commission and Veterans Administration in cooperation with the American Red Cross, the National Nursing Council for War Service and the American Hospital Association.

More than 130,000 professional and nonprofessional workers, in addition to more trained volunteer nurse's aides, are needed immediately, according to authentic estimates.

Needed at once are 30,000 graduate nurses for general, tuberculosis and psychiatric hospitals; 8000 graduate nurses for public health nursing; 2000 nurses now, and 3000 later, for Veterans Administration hospitals, and 90,000 nonnursing hospital workers. In addition to the paid workers, 40,000 trained volunteer nurse's aides are needed.

The patient load is heavier than at any time since 1940. Even discharged Army and Navy nurses and nurses from closed war plants cannot be expected immediately to go into civilian hospitals. The service nurses require a well-deserved rest; the industrial nurses will probably remain in the industrial field. The first classes of cadet nurses, now in training, will not become graduate nurses until next July.

A survey recently made by the American Hospital Association discloses that of 1060 hospitals (affiliated with the association) 23 per cent have closed beds, wards and sections as a result of the shortage of nurses and other personnel. Hundreds of hospitals still have long waiting lists of patients requiring hospitalization, this in spite of the fact, the survey report states, that many nurses are working longer shifts and most of them under unwholesome tension. The survey shows further that in 1944 general hospitals with schools of nursing attached were able to provide patients only thirty-five minutes' care by graduate staff nurses every twenty-four hours, or about half the minimum.

Neff to Be Head of Methodist Hospital

Robert E. Neff, administrator of the University of Iowa Hospitals since 1928, will return to Indianapolis within the next two months as superintendent of the Methodist Hospital, Indianapolis. Mr. Neff was president of the American College of Hospital Administrators in 1934-35 and president of the American Hospital Association in 1937-38.

Mr. Neff was assistant to the bursar of the University of Indiana from the time of his graduation there in 1911 until 1913 when he was named administrator of the Indiana University Hospitals, a position he held until he went to Iowa. He has been president, also, of the Indiana Hospital Association, Iowa Hospital Association, Children's Hospital Association, University Hospital Executives Council and Indianapolis Council of Social Agencies.

He has served on numerous state and national committees and commissions. Since 1935, he has been a member of the editorial board of THE MODERN HOSPITAL.

Nurse Scholarships Offered

Qualified nurses interested in preparing for orthopedic nursing positions in hospitals and in the public health field may apply for scholarships for advanced study. The scholarships cover tuition, travel expenses to and from the university and monthly stipends. Information can be obtained by writing to the Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York 19, N. Y.

Physicians' Committee Presents Analysis of Wagner Health Bill

A summary and critical analysis of the Wagner-Murray-Dingell Bill (S.1050) has been released by the Committee of Physicians for the Improvement of Medical Care, Inc., headed by Dr. Channing Frothingham.

After outlining in detail the provisions contained in the five major sections of the bill, the committee report discusses the implications and makes recommendations for still greater improvements, calling particular attention to certain points in which the committee feels that S. 1050 fails to safeguard or promote the best interests of the quality of medical care.

On the whole, however, the report endorses the principles of the bill, asserting that it is distinctly superior to previous bills purporting to institute a national health program. Most of the criticisms advanced by the committee against preceding bills, it is pointed out, have been intelligently considered and obviated in the new bill.

It is urged that hearings be held promptly to permit further improvement of S. 1050 and to advance its passage.

ASA S. BACON DIES

Asa S. Bacon, 79, former superintendent of Presbyterian Hospital, Chicago, and nationally known in the field of hospital administration, died recently at his home in Dowagiac, Mich. Associated with Presbyterian Hospital since 1900, Mr. Bacon had served as its superintendent for thirty years. Upon his retirement in 1941, he was named superintendent emeritus and an honorary staff member.

Mr. Bacon had been president and treasurer of the American Hospital Association, was founder and first president of the Chicago-Cook County Hospital Association, founder of the American Protestant Hospital Association and founder and charter member of the American College of Hospital Administrators.

Eligibility Provisions for Care in V. A. Facilities

An order issued by the Veterans Administration on October 8 contains details of the eligibility requirements for persons seeking medical, hospitalization and domiciliary care in Veterans Administration facilities.

Among the categories covered by the order are the following: persons entitled to hospital observation and physical examination; persons entitled to hospital treatment or domiciliary care; eligibility for hospital treatment or domiciliary care of persons discharged or retired from military or naval service. These categories cover both service and nonservice-connected disabilities.

No mention is made in the order of the possibility, advanced by various groups, of rendering care to veterans in local community hospitals, with the Veterans Administration paying for such care on a cost basis.

Actress Honored by U.S.P.H.S.

WASHINGTON, D. C.—Helen Hayes has been presented with a certificate of merit by Dr. Thomas Parran of the U. S. Public Health Service in recognition of her outstanding war work, particularly the recruitment of nurses. She was also given a pin especially made for her and bearing the seal of the Public Health Service by Lucile Petry, director of the cadet nurse corps. Miss Hayes appeared on a radio program for eighteen weeks, dramatizing true stories about nurses.

M.G.H. Takes Action to Help Alleviate Shortage of Beds

Because of the acute shortage of personnel and the closing of a second floor at Baker Memorial, Massachusetts General Hospital, the problem of hospital accommodations for patients was reviewed and plans were developed whereby the doctor may help his patients, according to N. W. Faxon, M. D., director.

The plan embodies three major points: maximum utilization of beds, sufficient advance notice in discharging patients and scheduling the admission of patients according to type.

Responsibilities of the staff doctor include shortening the postoperative care. If convalescence at home is not to be satisfactory, the social service department is to be consulted well in advance of the patient's discharge. Hospitalized patients are to be given from two to five days' notice of tentative discharge dates in order to make any necessary arrangements.

The admitting office is to schedule patients according to urgency, classifying them into three groups: emergencies, malignancies and semielectives. The cancellation of appointments for less urgent cases may at times be necessary, regardless of whether such appointments have been made for weeks or months in advance. Such canceled patients will be placed on a "calling basis" for those more ill and a new future appointment will be made for those for whom semielective care is indicated.

Virus Laboratory Built at Health Institute

Construction work on the new Virus and Infectious Diseases Laboratory of the National Institute of Health at Bethesda, Md., has been started by the Public Buildings Administration of the Federal Works Agency.

New laboratory appurtenances will be installed for the protection of the research scientists and laboratory technicians who brush death in their pursuit of knowledge to conquer the "dangerous" diseases. One of these is the recently developed equipment by which controlled air currents move over infected agents and into exhaust flues wherein both air and deadly air-borne bacteria are completely destroyed in the 700° F. heat of electric grids. Adequate protection of laboratory personnel can be obtained, the U. S. Public Health Service insists, only through the construction of a carefully planned and equipped building in which the most highly infectious agents can be concentrated. The recent deaths of two research workers have been attributed directly to their efforts to seek a vaccine for the tsutsugamushi disease, or scrub typhus. The war, particularly in the Pacific, has also intensified the activities of the institute.

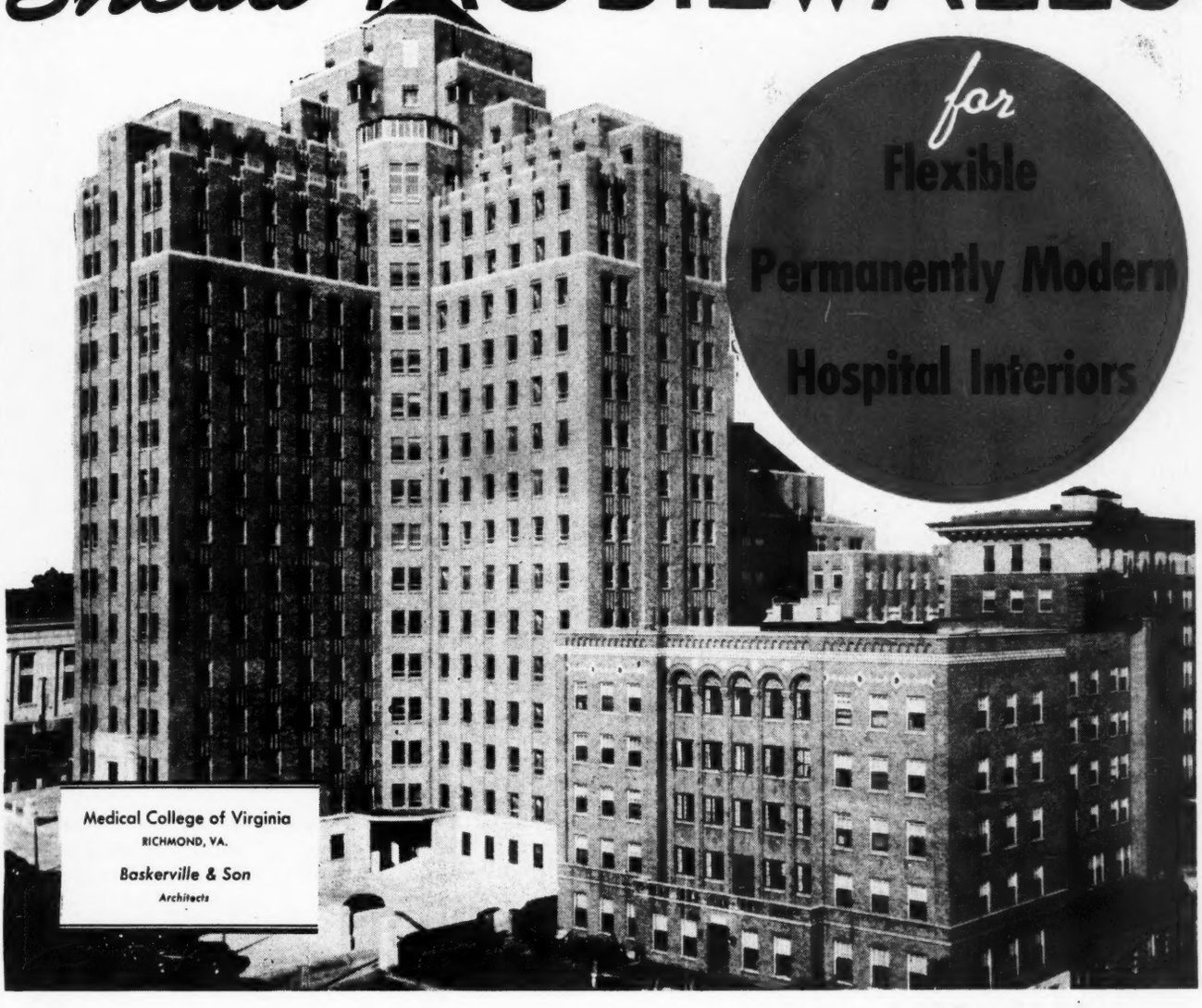
Golden Jubilee of X-Rays

The fiftieth anniversary of the discovery of the x-ray will be observed nationally during the week of November 5 to 10 under the sponsorship of the American College of Radiology according to Mac F. Cahal, executive secretary of the organization. The observance will emphasize the health attributes of x-rays in medicine and will help to acquaint parents with the importance of radiology in the early detection of disease in youngsters, Mr. Cahal explained.

120 Attend U. of C. Institute

A total of 120 students from 32 states, five Canadian provinces and four South American countries registered for the thirteenth Institute for Hospital Administrators held September 17 to 28 at the University of Chicago. Only 11 of these were from Illinois. In addition, there was a waiting list of approximately 100 persons who could not be accommodated in the institute.

Snead MOBILWALLS



Baskerville & Son, architects who designed the Medical College of Virginia, were cognizant of the everchanging needs of such an institution. Snead Semi-flush Mobilwalls and hollow metal doors were specified for corridors and dividing walls to secure maximum flexibility of interiors. Classrooms and laboratories can be enlarged or reduced quickly and easily without interruption of schedules and without dirt or muss.

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University of Chicago Sets Up Institute for Study of Cancer

A new enterprise, to be known as the Institute of Radiobiology and Biophysics, has been established at the University of Chicago, Chancellor Robert M. Hutchins announced recently. It will be headed by Raymond E. Zirkle, professor of botany.

The institute staff will study problems relating to cancer, age and heredity and will also seek to perfect technics for protecting workers using radioactive materials.

Members of the new institute will also cooperate with those of the Institute of Nuclear Studies, recently inaugurated as an outgrowth of the project which perfected the principles of the atom bomb.

Hospital Library Course Offered by Minnesota

The University of Minnesota, in cooperation with the Minnesota State Department of Social Security, is offering a course in hospital librarianship. In addition to basic courses, the program will include the following special courses: library service in hospitals, book selection for hospital patients, reading and the mental patient, medical reference work and hospital library practice.

Students who are not candidates for the bachelor's degree in library science or the bachelor of science degree may be admitted to the special hospital library courses provided they have completed at least three years ot approved college work and at least two quarters of work in an approved library school or have an equivalent of approved experience in hospital library work.

Recommends Wage Increase

Hospitals in St. Louis were advised by H. J. Mohler, president of the city's hospital council, to give consideration immediately to the probable need to increase pay or decrease hours or both for graduate nurses. In suggesting some possibilities, Mr. Mohler outlined the practices followed by the Missouri Pacific Hospital of which he is president. He suggests consideration of an increase of $10 per month, making a minimum rate of $165 per month and a reduction from forty-eight to forty-four hours per week.

Hospital Changes Name

The corporate name of Weymouth Hospital, South Weymouth, Mass., has been changed to South Shore Hospital, according to Arthur H. Perkins, M.D., director.

Veterans Given Care in Jail; Arizona Seeks New Hospital

A delegation from the state of Arizona, meeting with President Truman and Gen. Omar N. Bradley, head of the Veterans Administration, urged establishment of a 3000 bed veterans' hospital near Phoenix. The state is so overcrowded with World War II veterans in need of hospitalization that some have had to be placed in the Phoenix jail and in mental disease hospitals and others are living in tents and trailers on the Arizona desert.

Maj. Marvin Smith, chairman of the delegation of 25, says that the Arizona situation has been made especially serious because of the increasing number of veterans from other states who are going to Arizona for their health. Representative Harless (D., Ariz.) asserted that "immigrant veterans," those from other states, are living in tents and trailers on the desert in an effort to regain their health.

Arizona has two veterans' hospitals, one at Prescott and one at Tucson, with a total bed capacity of 810, but Major Smith explains that both are filled to overflowing.

Committee Reports on Survey to Aid Alcoholics

Owing to the lack of facilities for the care and treatment of alcoholics in the New York area, the committee of public health relations of the New York Academy of Medicine is conducting a survey on this program. Every doctor, hospital, sanitarium and other type of health facilities for treating in-patients has received a questionnaire asking for complete information on its methods of handling alcoholics.

Hospitals in particular were asked whether they treat alcoholics for complication of diseases, how many patients are treated, what proportion of acute cases ask for treatment of addiction, what treatment is used and whether follow-up services are provided.

Replies indicate that they sometimes find that patients admitted for other diseases are found to be suffering from chronic alcoholism. The subcommittee, of which Dr. Hubert S. Howe is chairman and Dr. E. H. L. Corwin is secretary, hopes to make an additional report late this fall.

Mental Hygiene Group Reports

The recent organization of a rehabilitation clinic for veterans and a two day Institute on Readjusting With the Returning Servicemen, sponsored by the Illinois Society for Mental Hygiene, represent the first organized efforts in the country to call attention to the fact that readjustment from war to peace is not a veteran's problem or a question of rehabilitating the returned servicemen but a problem of readjusting *with* the returning servicemen. According to the society's semiannual report, the organization has pioneered for new and better health procedures and practices for thirty-five years, not only anticipating the psychiatric needs of the community but stimulating and fostering the development of services and facilities to meet those needs.

British Hospitals Seek Flag

The British Hospitals Association announced recently that steps are being taken to obtain from the College of Arms letters of patent for the voluntary hospitals to fly a flag of their own. Designs have been submitted, and a prize of £5 will be awarded the winner by Col. N. Gervis Pearson of the General Hospital, Nottingham. Competitors were reminded that the design should not result in the purchase price of the flag's being too high to enable hospitals to use it and make necessary replacements. The decision of the executive committee of the B.H.A., with which Colonel Pearson will be associated, is final.

British Doctors Recommend Reforms in Staffing Hospitals

In England, the Ministry of Health has completed a hospital survey preparatory to the government project for a complete national health service.

A report by Drs. A. H. M. Gray and Andrew Topping on the district covering London and the surrounding area shows the inhabitants number 14,000,000. There are some 380 governing bodies of voluntary hospitals, 25 major hospital-owning local authorities, 20 minor authorities, with maternity homes, and 130 isolation and smallpox hospitals also provided by local authorities. In 1938, the voluntary hospitals admitted 473,000 patients and the municipal hospitals, 477,000, but the voluntary hospitals dealt with eight times as many out-patients as the municipal.

Reflecting a poor distribution of consultants in the area, the report is critical of the large amount of surgery done in the small hospitals by general practitioners. In the area as a whole, there is a gross deficiency of beds, and the care of the chronic sick is unsatisfactory.

Gray and Topping condemn the general practitioner hospital as a surgical specialist center, saying each such hospital should be attached to a district hospital staffed with specialists. They assert that the main district hospital should not contain more than 1000 beds or fewer than 400.

A third type of "special center" has been proposed to serve areas much wider than those of district hospitals, this type to include such special hospitals as fever, chest and orthopedic.

The most urgent single improvement, according to the two doctors, would be in the staffing of hospitals. To make the best use of the specialists available, decentralization from London is urged with payment of the specialists sufficiently adequate to compensate for their breaking ties with London.

U.H.F. Campaign Launched; Goal Is $1,661,255

The United Hospital Fund has collected 22 per cent of its campaign goal of $1,661,255.74, it has been announced by James S. Adams, citywide chairman of the sixty-seventh annual drive. The sum will be used for the benefit of the 86 voluntary, nonprofit hospitals and homes associated in the fund and represents the difference between hospital income and operational costs in 1944.

Last year the organization exceeded its goal of $1,554,931. This year's increased demands for the services of the voluntary hospitals as an aftermath of the war are being stressed in the appeal of the 1945 campaign.

COMING MEETINGS

AMERICAN HOSPITAL ASSOCIATION, Trustees, Drake Hotel, Chicago, Nov. 2-3.

AMERICAN HOSPITAL ASSOCIATION, House of Delegates, Drake Hotel, Chicago, Nov. 5-7.

AMERICAN MEDICAL ASSOCIATION, House of Delegates, Palmer House, Chicago, Dec. 3-6.

ARKANSAS HOSPITAL ASSOCIATION, Hotel Albert Pike, Little Rock, May 17-18.

ASSOCIATION OF CALIFORNIA HOSPITALS, San Francisco, April.

BLUE CROSS PLANS, Hotel Commodore, New York City, Oct. 29-31.

HOSPITAL ASSOCIATION OF NEW YORK STATE, Hotel Pennsylvania, New York City, June 10-12.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Hotel Bellevue Stratford, Philadelphia, April 24-26.

IOWA HOSPITALS ASSOCIATION, Hotel Fort Des Moines, Des Moines, April 15-17.

KENTUCKY HOSPITAL ASSOCIATION, Hotel Brown, Louisville, April.

MISSOURI HOSPITAL ASSOCIATION, Hotel Chase, St. Louis, Nov. 15-16.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Morrison Hotel, Chicago, Feb. 6-7.

NORTH DAKOTA HOSPITAL ASSOCIATION, Hotel Ryan, Grand Forks, May 9-10.

OHIO HOSPITAL ASSOCIATION, Hotel Deshler-Wallick, Columbus, April 2-4.

OKLAHOMA STATE HOSPITAL ASSOCIATION, Cushing Hotel, Cushing, Nov. 16.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 1-3.

UTAH STATE HOSPITAL ASSOCIATION, Salt Lake City, Dec. 6.

WISCONSIN HOSPITAL ASSOCIATION, Hotel Schroeder, Milwaukee, February.

Rhode Island, New Jersey Blue Cross Plans Announce New Benefits

Rhode Island Blue Cross plan celebrated its sixth birthday by conducting a successful individual enrollment campaign, enrolling its 300,000th subscriber and proclaiming that it had reached a total of 43 per cent of the population of the state.

Individual enrollment was offered to persons under 66 years of age who are self-employed or not employed or who work in places with 10 or fewer employes.

Those who accept such enrollment may receive up to thirty-one days of hospital care for each contract year. This is an increase of ten days over the program offered during 1944. Likewise, maternity benefits have been increased from $54 to $65.

The Hospital Service Plan of New Jersey announced that war workers who have left their jobs can continue to be protected by simply making subscription payments directly to the plan or through another place of employment. For a temporary period the subscriber will pay the low monthly group rate that obtained while he was under the pay roll deduction plan in the war industry. After the subscriber has made the payment for the bill sent to his home for the temporary period, he will be billed thereafter at the direct payment rate unless he becomes employed in another organization where a group is enrolled, in which case his rate continues unchanged at the low monthly group rate.

On October 17, the New Jersey plan announced that arrangements had been completed with the American Express Company to accept subscription payments from subscribers. This will further facilitate payments by subscribers who have left their jobs and may not have checking accounts. The American Express will make a nominal charge of 5 cents for each bill collected regardless of the amount of the bill.

F.D.R. to Be Honored by Cuba

Because of his own conquest of infirmity, his inspiration to the physically handicapped and his friendship for the peoples of Latin America, Havana will name its proposed $500,000 rehabilitation center for the crippled in honor of the late Franklin Delano Roosevelt. Dr. Jose Ignacio Tarafa, Havana physician and surgeon, who is here on a tour of hospitals and rehabilitation centers in the United States, has disclosed the project. Funds for the Cuban center are being raised there by public subscription under the sponsorship of the Havana Rotary Club.

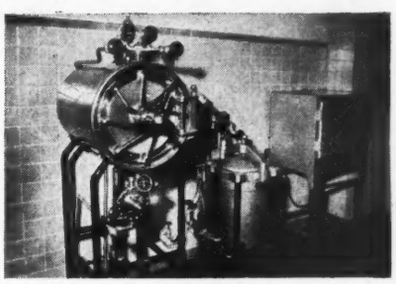
Formula Room. Pressure sterilizer technique with new centralized control.

Central Supply. Sterile Storage.

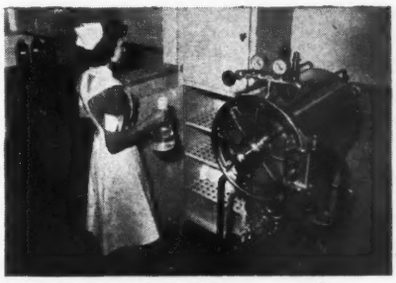
AULTMAN HOSPITAL'S *New Wing Ultra-Modern and Scientific*

The new McKinley Wing of the Aultman Hospital, Canton, Ohio, is scientifically designed for increased safety and efficiency in every phase of hospital operation. Particularly interesting is the Castle Planned Installation of Sterilizers and Surgical Lights based on new and advanced ideas of equipment grouping and location.

If you are considering modernization or new construction, Castle engineers are at your service. For further information write: Wilmot Castle Company, 1175 University Avenue, Rochester 7, New York.



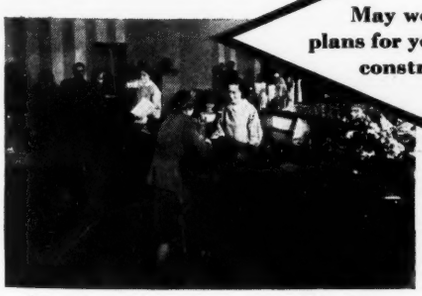
Surgery-Sterilizer Room



Utility Room. Pressure sterilizer technique.

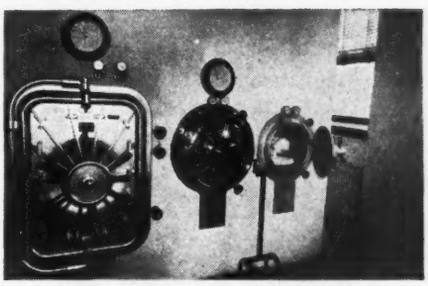
Castle LIGHTS AND STERILIZERS

May we submit plans for your proposed construction?



Smartly styled Coffee and Gift Shop.

Typical Operating Room with Major Surgical Light and Emergency Spotlight.



Central Supply-Work Room. New and modernized equipment.

Find Facilities for Invalids Inadequate

About 90,000 persons in Illinois are chronic invalids, two thirds of them being under the age of 65. The existing facilities for their care are insufficient and so unequally distributed as to present a serious problem. Chronic illness is not confined to the indigent, although it bears more heavily on them.

These are findings of an interim report, published on September 9 by a committee to investigate chronic diseases among indigents.

The committee recommends that general hospitals should set aside more beds for patients who are chronically ill and should establish facilities for their care.

It also recommends that county homes which can be converted to homes for the infirm and chronically ill should be so converted. Proper regard should be given to construction, sanitation and general hygiene in these homes so as to safeguard patients. There are now 7264 beds in 72 such homes in Illinois. An act permitting such conversion was passed by the 1945 legislature and signed by the governor.

The establishment of more tuberculosis sanatoriums, more infirmary facilities in nongovernmental institutions for the aged, more private nursing homes and homes for convalescent care and additional home nursing and housekeeping services was recommended.

In connection with private nursing homes the committee urged competent management, proper standards and licensing and supervision by a state agency or by local governments in conformity with state standards.

Russia Tells Need for More Doctors

The 130,000 doctors now practicing in Soviet Russia are inadequate to meet that nation's needs and to staff its increasing number of medical institutes, according to the Moscow correspondent of the *Journal of the American Medical Association.*

The Moscow Medical Institute, which is celebrating its 180th anniversary this year, has trained 34,000 doctors and now has a student body of 4000. The course of study has been increased from five to six years, but there are no tuition fees and 95 per cent of the students receive financial aid from the government.

Students who attain a high average and display ability for research and teaching are encouraged to continue their work at the institute in a three year postgraduate course during which they receive government stipends large enough to enable them to devote themselves entirely to their work.

How to Apply for V.A. Position

WASHINGTON, D. C.—Army and Navy nurses who wish to make application for a position with the Veterans Administration following their release from the service should include date of military separation and submit applications not more than 30 days in advance of that date, according to Gwen H. Andrew, R.N., superintendent of nurses for the Veterans Administration. "Without termination date and complete information it is impossible to process applications," said Miss Andrew.

May Change Name of Center

WASHINGTON, D. C.—The Navy Department has indicated that it favors changing the name of the Naval Medical Center, Bethesda, Md., to the Franklin D. Roosevelt Naval Medical Center, according to a recent statement of Representative Flood. A letter from Assistant Secretary of the Navy, John L. Sullivan, to Mr. Flood said that naming the hospital in honor of the late President would be most appropriate. Representative Flood introduced the bill proposing the change shortly after Mr. Roosevelt's death.

OFFICIAL ORDERS
August 18 to October 18

Automatic Electric Temperature Control Equipment.—An industry-wide price increase factor of 5 per cent was established by O.P.A. on October 9 for use in computing reconversion ceiling prices. Both manufacturers and resellers of automatic electric temperature controls for all heating, air conditioning and refrigeration, except industrial processing controls, may calculate their new 1945 ceiling prices by adding 5 per cent to their prewar prices.

Bath Towels.—All sizes and weights may now be produced for civilian use. War-time controls have been removed through amendments to L-99.

Canned Milk.—All restrictions on the acquisition, transfer, and use of canned milk by hospitals and other institutional users were revoked through an amendment to GRO 5 on September 1. The reduction of military and lend-lease acquisition of canned milk has resulted in a supply equal to all civilian demands for the product.

Canned Salmon.—Amendment 13 to War Food Order 44, effective August 25, ensures that 7,500,000 additional pounds of this year's pack will enter civilian trade channels. Most of this salmon will be in half pound cans.

Canned Vegetables.—A greatly increased civilian supply is anticipated because of a larger indicated pack and reduced military requirements. Amendment 5 to War Food Order 22.9 became effective August 24 and reduced government set-aside percentages to such an extent that nearly 40,000,000 additional cases of canned vegetables will be available to the general public.

Cheese.—Amendment 5 to War Food Order 15, retroactive to September 1, removes all government controls on the manufacture and distribution of cheese. W.F.O. 92 was terminated as of the same date. Point values were completely removed on this item as of 12:01 a.m., September 12.

Citrus Fruit.—No longer does the government regulate the setting aside, manufacture and sale of citrus fruit juices to meet the need of the armed forces. War Food Orders 3, 6, 118 and 122 have all been terminated as of August 27.

Dried Milk Products.—These are once more available in ample quantity since government restrictions were removed by the termination of War Food Order 93, retroactive to July 1, but not announced until August 28.

Fats and Oils.—Fourth quarter allocations of fats and oils other than butter have been announced by the U. S. Department of Agriculture, as follows: **Lard**—for civilian use totals 430 million pounds, substantially above the allocation for the third quarter of 1945. **Margarine**—of the 128.8 million pounds available for allocation in the fourth quarter, 112.3 million pounds go to civilians. **Shortening and Other Edible Oils**—civilian allotment for the fourth quarter is 504.7 million pounds. **Inedible Fats and Oils**—791 million pounds will be available for civilian use.

First-Aid Dressings.—Army Carlisle model small first-aid dressings declared surplus by the Army may be sold at a retail ceiling of 25 cents per package when repacked four to a package, O.P.A. announced October 2.

Lumber.—The over-all control order was drastically relaxed August 22. Lumber will be immediately available to distribution outlets and within thirty days sufficient amounts will be on hand to meet all kinds of construction requirements. Softwood plywood will also be available to civilians through revocation of lumber controls. By October 1 distribution of lumber was free from control, according to a pronouncement of the War Production Board on September 12. However, no appreciable replenishment of lumber stocks, which are now at an all-time low, can be expected during the fourth quarter of 1945 because of sharp cuts in production.

Milk Sugar.—No longer need producers and handlers periodically report to government agencies their production, distribution and sale of this commodity. There is now an adequate supply and War Food Order 95 was terminated on August 26.

Penicillin.—W.P.B. announced that effective August 31 all its restrictions on the use and allocation of this drug were removed.

Pillows.—War Production Board Limitation Order M-102 was recently revoked, according to an O.P.A. release of August 31, 1945. This means that pillows for civilian use may once more be filled with new goose and duck feathers and down. Ceiling prices will be in line with existing ceilings for comparable goods, O.P.A. said.

Poultry.—War Food Orders 119, 125 and 142 were terminated or suspended by the U. S. Department of Agriculture, effective August 27. They were designed to help the armed forces procure sufficient poultry but reduced needs because of the termination of the war make them no longer necessary.

Quinine.—An amendment to Order M-131, September 5, once more permits the allocation of this drug for civilian antimalarial and other medical purposes. No quinine will be authorized for use in combination with other medicinal ingredients. It is to be used only for the filling of physicians' prescriptions and the manufacture of capsules, tablets and other dosage forms of quinine alone. Quinidine is still in critical supply.

Rationing.—Under amendment 114 to GRO 5, effective August 16, an institutional user may be granted a supplemental allotment of a rationed food if he serves meals during the current allotment period to a number of persons that is more than 10 per cent larger than the number he served during the preceding allotment period. An amendment of August 22 concerns petitions for loan of meat-fats points by Groups II, III, IV or VI.

Refrigerators.—Distribution controls governing domestic mechanical refrigerators were revoked October 10. Of the half million used refrigerators made subject to an inventory freeze early in the war by the W.P.B., about 15,000 remain in the stockpile. When these are released for general sale, they will remain subject to the two existing regulations, one for manufacturers and one for distributors and dealers, governing sales of new household refrigerators, O.P.A. announced. Refrigerators manufactured after July 1, 1945, will be covered by a new regulation to be announced shortly.

Safety and Technical Equipment.—Order P-43 covering equipment for laboratories was revoked September 30.

Stainless Steel.—Price control was suspended for stainless steels as of October 16.

Steel, Copper, Aluminum.—The Controlled Materials Plan for the distribution of these materials was revoked September 30. Controls on the production and distribution of metals, except tin, lead and antimony, expired with the revocation of CMP and only the emergency AAA rating, MM rating for military needs and the CC rating for emergency civilian requirements remain in force.

Tea.—Supplies have been almost normal since the first of the year and the termination of War Food Orders 18 and 18.3, effective August 21 removed the last controls over this commodity.

Columbia University Trains Medical Officers

Medical officers who were graduated under the accelerated program of medical education and who have had only an abbreviated hospital training before entering military service will have the opportunity for three types of training this fall at Columbia University School of Medicine. These will comprise short refresher courses in every branch of medicine, full-time clinical training at the residency level and a general review program of the basic sciences and major clinical fields.

Certain of these refresher courses are for general practitioners while others will be for men already qualified in one of the specialties. Appointments to hospital resident services will be made as in the past by the individual hospitals usually for periods of one year or longer.

Dr. Willard C. Rappleye, dean of the Faculty of Medicine, in making this announcement indicated that most American hospitals are planning to increase the number of residencies to offer additional training to graduates of their house staffs.

Nursing Bulletin Resumed

The International Council of Nurses announced on August 29 the publication of the *International Nursing Bulletin*, a four page quarterly successor to the *International Nursing Review*, which was suspended in 1939 because of the war. The first issue of the new bulletin is to appear in October. It will be increased in size and scope until it becomes a full-fledged international review. The council has offices at 1819 Broadway, New York 23, N. Y.

Emch Out of Navy

Cmdr. Arnold F. Emch, now on inactive duty with the Navy, will be associated with the firm of Booz, Allen and Hamilton, Management Engineers, Chicago. Mr. Emch will be in charge of a new department on institutional management whereby the facilities and services of this firm will be made available to universities, hospitals and other organizations.

Illinois Names 20 to Survey Committee

The advisory committee for the Illinois Hospital Survey has elected an executive committee of 20 members to direct the study. Dr. Robert S. Berghoff, president-elect of the Illinois State Medical Society, is chairman of both the advisory council and the executive committee. Dr. Henrietta Herbolsheimer of the state health department is director and executive secretary of the study.

Preliminary schedules were sent out to hospitals in September, and it was hoped that they could be collected beginning September 20.

In Wisconsin the hospital survey is to be directed by Vincent F. Otis, business administrator of the Milwaukee Asylum for Chronic Insane at Wauwatosa. Dr. Gunnar Gundersen of La Crosse, president of the state board of health, is chairman of the hospital advisory committee in Wisconsin.

The Commission on Hospital Care reported on October 17 that all 48 states and the District of Columbia have taken some action toward a survey.

Issue Accounting Manual

A 52 page "Hospital Accounting Manual" was distributed during September by the Rochester Hospital Council, Rochester, N. Y., as a result of the work of its accountants' committee, headed by Seward G. Smith of Genesee Hospital, chairman. The manual is expected to be a forward step in the development of uniform cost accounting. It was approved by various auditing firms and by the Rochester Community Chest. It consists of a series of financial statements, each of which is followed by definitions of the terms used.

Blue Cross Plans to Meet

A national convention of Blue Cross plans was held at the Commodore Hotel, New York City, October 29 to 31. Among important subjects to be considered were payments to hospitals, national legislation, the Blue Cross approval program, enrollment of veterans, reciprocity among plans and continuation of membership by people who are laid off.

Call Tuberculosis Conference

A conference on Control of Tuberculosis in a Metropolitan Area will be sponsored by the Institute of Medicine of Chicago November 13 and 14 at the Palmer House, Chicago. The conference will cover phases of particular importance to clinicians, specialists, lay workers and teachers who are invited to attend.

Georgia Association Names New Officers

The Georgia Hospital Association has announced its new officers for 1945-46 as follows:

President, Fred M. Walker, Grady Memorial Hospital, Atlanta; president-elect, H. Louie Wilson, Phoebe Putney Memorial Hospital, Albany; secretary-treasurer, Sister M. Cornile, R.S.M., St. Joseph's Infirmary, Atlanta.

Trustees are Agnes P. McGinley, Athens General Hospital, Athens (1945-48); John C. Richard, Warren Candler Hospital, Savannah (1945-48); Dr. L. C. Fischer, Crawford W. Long Hospital, Atlanta (1943-46); Dr. C. L. Ridley, Macon City Hospital, Macon (1944-47).

Because of transportation difficulties, the election was conducted by mail.

New Rochelle Adds Beds

Shortly after Labor Day work was started on a new building program for New Rochelle Hospital, New Rochelle, N. Y. This includes an additional 40 adult beds, 15 extra bassinets and 11 extra beds in the pediatric department. A fund-raising campaign for $750,000 is expected to reach its goal the first of the year. Shreve, Lamb and Harmon, New York City, are the architects for the new addition.

Mount Sinai Unit Returns From Overseas

The Third General Hospital, overseas unit of Mount Sinai Hospital, the first of the general hospitals of the U. S. Army from New York to return to the United States, arrived September 15 on the *S.S. General Stewart* after more than two years abroad.

The unit arrived in North Africa in May 1943. Originally meant to be a 1000 bed hospital, an expansion tent unit providing for an additional 1000 beds was immediately erected. The hospital rarely had fewer than 1500 patients and, at times, treated as many as 2000.

The unit was recommended for a military citation.

Stipends Exempt From Tax

WASHINGTON, D. C.—Tuition and maintenance stipends paid to defray expenses connected with training of personnel under the maternal and child welfare activities of the Social Security Act are considered as gifts for federal income tax purposes and are not wages subject to withholding, the *Internal Revenue Bulletin* of September 11 reported. Although the decision did not mention similar stipends paid to cadet nurses, they presumably would come under the same rule.

DDT in Paint Products

Laboratory and field tests over the last twelve months prove that highly satisfactory control of flies, silverfish and mosquitoes can be obtained with properly formulated interior finishes incorporating the war-developed insecticide DDT, it has been announced. Several manufacturers have prepared DDT finishes but will not release their products to the consumer until toxicological and service tests prove beyond question their suitability for household and institutional uses.

Few Loans Made to Hospitals

WASHINGTON, D. C.—Although federal loans are available to assist local governments in drawing up plans for public works, relatively few of them have been made for hospitals. During September, $9000 was advanced in Utah to prepare plans for two hospital projects which will cost $169,600 and $81,620, respectively, and $34,850 to Massachusetts to prepare plans for a 300 bed tuberculosis hospital as an addition to the Westborough State Hospital. It is estimated that the latter project will cost $967,000.

Convalescents Play "Typatune"

The Army Air Forces Convalescent Hospital, Plattsburg, N. Y., has a new therapeutic gadget known as a "Typatune." A musical instrument that looks like a portable typewriter and weighs only 5 pounds, the "Typatune" plays a full range of classical or popular music from a standard typewriter keyboard. The "Typatunes" were given to the hospital by Samuel Goldstein, chairman of the welfare committee of Liberty Post No. 22 of the American Legion, and Samuel J. Novick.

Beekman-Downtown Seeks Funds

A campaign to raise $2,750,000 to build a new hospital to replace the present Beekman and Downtown hospitals, New York City, is now under way. This new 200 bed institution will be known as the Beekman-Downtown Hospital and will serve all Lower Manhattan south of Canal Street, comprising the Wall Street financial district, insurance, shipping, textile, wholesale and City Hall building centers, with a working population of more than a million and a resident population of 40,000.

E.M.I.C. Ruling Interpreted

Wives and children of servicemen who are enrolled in Blue Cross plans may obtain benefits under the E.M.I.C. program or under the Blue Cross but may not have both, according to an announcement by C. Rufus Rorem on September 5.

50,000 Patients Treated at Mount Sinai Hospital

Despite war-time conditions, more than 50,000 patients were treated at Mount Sinai Hospital, New York City, in 1944, and the institution not only maintained its high standards of medical care but was able to develop plans for enlarged services, according to George B. Bernheim, president of the board of trustees, in his annual report.

Regardless of the loss of 756 members of the medical staff, nurses and other personnel to the armed services, the daily average number of patients was greater in 1944 than in 1943; there was a large increase in the number of students enrolled in the postgraduate medical courses given at the hospital in affiliation with Columbia University's College of Physicians and Surgeons, and research covered a broad range of scientific and clinical interest.

The Neustadter Home, convalescent branch of the hospital in Yonkers, reports that during 1944, 18,051 days of care were administered to 851 patients.

Australia Plans Association

Preliminary steps are being taken in Australia to form an Australian Hospital Association similar in functions to the American Hospital Association. The new association would not usurp the functions of the state hospital associations which are recognized by statute. Rather it would cooperate in affairs on a commonwealth-wide basis. An Australian Institute of Hospital Administrators is about to be registered at Canberra, according to the *Hospital Magazine*.

Offer Nursing Degree

Reading Hospital, Reading, Pa., has completed arrangements with Albright College to offer a five year course in nursing leading to the degree of bachelor of science. Young women desiring to attain a college degree in conjunction with the nursing school course will enroll at Albright College for a period of two years. Upon completion of the college course, they will then enter the school of nursing of Reading Hospital for three years at the conclusion of which the degree will be conferred.

New Hospital for Schenectady

A new 200 bed Catholic hospital, to be known as St. Clare's, and staffed by the Sisters of the Poor of St. Francis, is to be built in Schenectady, N. Y. The residents of this city raised $1,337,181 as a building fund, thereby oversubscribing their original goal of $1,200,000. The Very Rev. John J. Finn who is in charge of this project announces that the architect has been selected.

ABOUT PEOPLE

(*Continued from Page 90*)

American College of Hospital Administrators.

Albert J. Taylor has taken over his new post as administrator of Newcomb Hospital, Vineland, N. J. He formerly served as assistant superintendent of St. Luke's Hospital, Bethlehem, Pa., and Osteopathic Hospital, Philadelphia, and superintendent at the latter institution.

Charles B. Allen, superintendent of St. Luke's Hospital, Newburgh, N. Y., has been appointed administrator of Springfield City Hospital, Springfield, Ohio. He is a former assistant administrator of St. Luke's Hospital, New York City.

Dr. W. L. Potts is the new administrator of Franklin County Tuberculosis Hospital, Columbus, Ohio. Prior to accepting his present post, Doctor Potts was in charge of Hillsborough County Tuberculosis Hospital, Tampa, Fla.

Jerome F. Peck, superintendent of Binghamton City Hospital, Binghamton, N. Y., has resigned to accept the post of hospital consultant with the firm of Con-

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rad and Cummings, associated architects, Binghamton. Mr. Peck is a fellow of the American College of Hospital Administrators and a past president of the Hospital Association of New York State.

Frank Bosquet has been appointed administrator of Augusta General Hospital, Augusta, Me. He has recently returned from overseas, having served for a year in Africa and Italy as medical requirements specialist and administrative officer of the health division of U.N.R.R.A.

Homer Alberti, former business manager of Bethany Hospital, Kansas City, Kan., is the new administrator of Winchester Memorial Hospital, Winchester, Va.

Ross O. Urban, assistant adjutant, Brooke Hospital Center, was appointed administrator of Memorial Hospital, Corpus Christi, Tex., on September 10.

Dr. Joseph Weinstein has been appointed assistant director of Israel Zion Hospital, Brooklyn, N. Y. Doctor Weinstein was formerly district health officer of the Corona-Flushing Health Center of the New York City Department of Health.

Rev. J. A. Schultz was appointed administrator of Evangelical Deaconess Hospital, Lincoln, Ill., October 1.

Mrs. Delight S. Jones has assumed her duties as administrator of Truesdale Hospital, Fall River, Mass.

J. T. Tollefson, formerly administrator of St. Luke's Hospital, Fargo, N. D., is the new administrator of Lutheran Hospital, Moline, Ill.

Faith Collins, superintendent of Kenosha Hospital, Kenosha, Wis., for twenty-two years, has submitted her resignation. Miss Collins, who plans to retire on December 1, received her training at the University of Chicago and Columbia University. Before going to Kenosha, Miss Collins was superintendent of nurses at Lincoln Sanatorium, Lincoln, Neb., superintendent of the Swedish-American Hospital at Rockford, Ill., and superintendent of the Corey Hospital, Corey, Pa.

Vernon T. Root, superintendent of Epworth Hospital, South Bend, Ind., resigned that post to become associated with Blue Cross Hospital Service of Indiana. He will work in the northern part of the state and will maintain his headquarters in South Bend.

Mrs. Elsie M. Denis has resigned as superintendent of Marcus Daly Memorial Hospital, Hamilton, Mont., to accept an appointment to the Office of Inter-American Affairs in Chile.

Lucina Reep, R.N., former superintendent of nurses, Middlesboro Hospital, Middlesboro, Ky., has assumed the duties of superintendent of Broward General Hospital, Fort Lauderdale, Fla. Her predecessor, **Mrs. Dorothy G. King, R.N.,** resigned to accept the position of superintendent of Putnam County Hospital, Greencastle, Ind. **Mary L. Margerum, R.N.,** former superintendent of Putnam County Hospital, is the new superintendent of Champaign County Home and Hospital, Urbana, Ohio.

Dr. Hart E. Van Riper, medical director of James M. Jackson Memorial Hospital, Miami, Fla., resigned that position to become assistant medical director of the National Foundation for Infantile Paralysis, with headquarters in New York City.

Dr. Kenneth B. Babcock has returned from Army duty to assume his former post as assistant director of Grace Hospital, Detroit.

Department Heads

Mrs. Olive M. Northwood has been appointed director of nursing service, Tompkins County Memorial Hospital, Ithaca, N. Y. Mrs. Northwood was previously director of nursing and principal of the school of nursing, Queen's Hospital, Honolulu, T. H.

Lois Scripter has assumed her duties as chief dietitian at Missouri Baptist Hospital, St. Louis.

Marjorie Sanderson has taken over the position of director of the school of nursing at Bethany Hospital, Kansas City,

Kan. For the last two years, Miss Sanderson has been assistant director at Henry Ford Hospital in Detroit.

Delia G. Dowling, supervisor of nurses at the Hospital for Joint Diseases, New York City, has retired after twenty years' service. The hospital has announced the appointment of **Mrs. Bernice Huffman** as director of nursing service and director of the School for Practical Nursing, the latter a newly organized project this fall.

Marion Jones is the new chief dietitian at the University of Chicago Clinics succeeding **Ella Marie Eck** who has resigned to go into restaurant supervision under John C. Dinsmore, who was once superintendent of the university clinics. Miss Jones has been first assistant dietitian and cafeteria manager since 1935. She has had previous dietetic experience at two other Chicago hospitals, Cook County and Illinois Masonic, and has also been assistant manager of the Petit Gourmet restaurant, Chicago.

Mary Hurbert Lincoln is the new chief dietitian at Butterworth Hospital, Grand Rapids, Mich.

Lt. Col. John L. Sundberg, M.A.C., returned to his former position as purchasing agent of Emanuel Hospital, Portland, Ore., on September 10 after four and a half years of service. Colonel Sundberg was overseas in the Pacific for forty-one months, seven months of which were spent at a small station hospital on Canton Island. He spent two years in the Hawaiian Islands and also served in the Philippines since the invasion of Leyte as executive officer of the 165th Station Hospital.

Miscellaneous

Albert Whitehall, an attorney with the American Hospital Association, was transferred to Washington in September to work with **Russell Clark** of the A.H.A. council on governmental relations in the Washington service office. Mr. Whitehall will give particular attention to work on state legislation affecting hospitals. Before joining the staff of the American Hospital Association he was an attorney for the *Chicago Daily News*.

Lawrence W. Rember has resigned as public relations director for the Hospital Service Plan Commission to become assistant general manager of the Poultry and Egg National Board, Chicago. He was associated with the latter organization before entering the Blue Cross field which he has served for the last two years.

Lawrence J. Linck has been chosen executive director of the National Society for Crippled Children and Adults, Inc., a new position created by the society to extend and strengthen its program. The old position of executive secretary was eliminated with the resignation and retirement of **E. Jay Howenstine.** Mr. Linck has been executive director, Illinois Commission for Handicapped Children, and director of the division of services for crippled children, University of Illinois.

Glenn R. Studebaker, chief of the Hospital Facilities Section of the War Production Board, resigned on October 1 to join the staff of the Office of Surplus Property, U.S.P.H.S. Mr. Studebaker was associated with Albany Hospital, Albany, N. Y., for ten years prior to joining the W.P.B. He served as assistant director of the hospital in charge of the service division from 1935 until his departure for Washington in 1943.

Lt. Col. Mary Agnes Brown, former Wac staff director in the Pacific, has been named adviser on matters pertaining to women veterans, the Veterans Administration has disclosed. Colonel Brown, who holds the Legion of Merit, has reported to **Gen. Omar N. Bradley,** Administrator of Veterans' Affairs, to begin preparation for meeting the needs of the more than 300,000 women either serving or already released from the

armed forces. She has spent more than three years in the Army and twenty-two years in the Veterans Administration.

Maj. Margaret Janeway, M.C., A.U.S., assistant to the consultant for the women's health and welfare unit of the surgeon general's office, was retired from the Army recently. The first woman medical officer to go overseas, Major Janeway asked to be retired in order to resume her private practice in New York City.

Martha Dunlap has assumed the post of editor and advertising director of the *Journal of the American Association of Nurse Anesthetists*. She succeeds **H. C. Combs** who resigned. Miss Dunlap is also editor and advertising manager of a nationally circulated monthly trade journal in the transportation industry, a position she has held for the last ten years.

George Bugbee's title is now executive director of the American Hospital Association. For legal purposes, he will continue to be executive secretary of the association also.

Deaths

Mary A. Rostance Craddock, superintendent of Warren City Hospital, Warren, Ohio, from 1924 to 1937, died recently at her home in Bloxwich, Wallsall, England.

THE BOOKSHELF

PROBLEMS OF AGEING—BIOLOGICAL AND MEDICAL ASPECTS. *Second Edition. A publication of the Josiah Macy Jr. Foundation. Edited by E. V. Cowdry. Baltimore: The Williams & Wilkins Co.* 1942. *Pp. xxxvi and* 936. $10.

In a world that sacrificed its youth on the altars of glorious ideals and murky ideologies, it is fitting and, in fact, necessary that the problems of ageing be studied objectively for the better understanding, preservation and utilization of the vast human resources represented in the older age groups of the world's steadily ageing population.

The marshaling of facts, theories and provocative questions by the contributors to the first edition (1939) acted as a potent catalyst in this field of research. In the short interval between the publication of the first and second editions, a national scientific organization, a government agency, an international club of investigators and a philanthropic foundation have cooperated in a broad program to organize research on ageing. The results of an attack so well planned are bound to be successful in the near future.

The original volume has been revised to bring its material up to date and to include nine new chapters dealing, respectively, with the development of ageing of the respiratory system, of the teeth and jaws, of the prostate gland and of individual cells; histo-chemical changes with ageing; psychological guidance for older persons; diagnosis, prophylaxis and treatment in old age; the social urgency of research in ageing, and historical literary allusions to old age and ageing.

Since the first chapter discusses ageing in plants and the last is replete with human wisdom, the enormous sweep of this book is apparent. Throughout, the emphasis is on problems, on the unknown but not the unknowable, on the need for more facts, on the difficulty in the distinction between the pathology of age and "normal" ageing.

The hospital planner of the future should become familiar with "old age guidance centers" where the physician, psychologist, psychiatrist, occupational therapist, rehabilitation consultant, marriage broker, dentist and many others will fulfill their appropriate and coordinated functions. The motto of such a center would be: "No one ever lives too long to stop being a person."—LOUIS LEITER, M.D.

ONE HUNDRED YEARS OF AMERICAN PSYCHIATRY. *J. K. Hall, general editor.* Published for *the American Psychiatric Association,* New York. *Columbia University Press,* 1944. *PP. xxix*—649. $6.

It is curious that the oldest national medical organization in America should be that of the psychiatrists. In May of this year they celebrated the centennial of the organization of the body which later became the American Psychiatric Association. At the end of seventy-seven years of its existence it had a thousand members; in the next seventeen years it acquired another thousand; at the present time it has well over 3000 and applications for admission piling up on the secretary's desk.

Well they should, for it is not a secret that 10,000 psychiatrists would not constitute an oversupply for the needs of this country at the present time, to say nothing of the problems of the future. The fact that psychiatric cases outnumber all others both in the armed forces and in the civilian population while psychiatry remains one of the smallest specialties is one of the great medical paradoxes of modern times.

Beautifully printed on specially watermarked prewar paper, this book of 649 pages contains a series of essays on psychiatric development, psychiatric research, psychiatric literature, psychiatric therapy, psychiatric prophylaxis, psychiatry in the Army, psychiatry in the law courts, psychiatry in anthropology. These have been prepared by various leading psychiatrists, with varying degrees of brilliance and literary skill.

Skillful editing has made a well-knitted whole of the contributions; there is no feeling of repetition or overlap. A general impression is gained of the intense individualism of the psychiatrists and of the enormous scope and responsibility of their work.

Readers of this journal will perhaps take the greatest interest in the chapter on the history of American mental hospitals, which is necessarily much less complete than the definitive book by Albert Deutsch ("The Mentally Ill in America") and the four volume "History of the Institutional Care of the Insane in the United States and Canada," which was issued by the association 27 years ago.

It reviews briefly the founding of the original private and, later, public hospitals for the care of the mentally ill with emphasis upon the great contributions of Dr. Thomas S. Kirkbride and Dorothea Lynde Dix. Kirkbride's influence upon the architecture of mental hospitals in America was enormous but no greater than the influence of Miss Dix upon the spirit of these hospitals.—KARL MENNINGER, M.D.

FREEDOM FROM FEAR. *By Louis H. Pink. New York City: Harper and Brothers.* 1944. *Pp.* 254. $2.50.

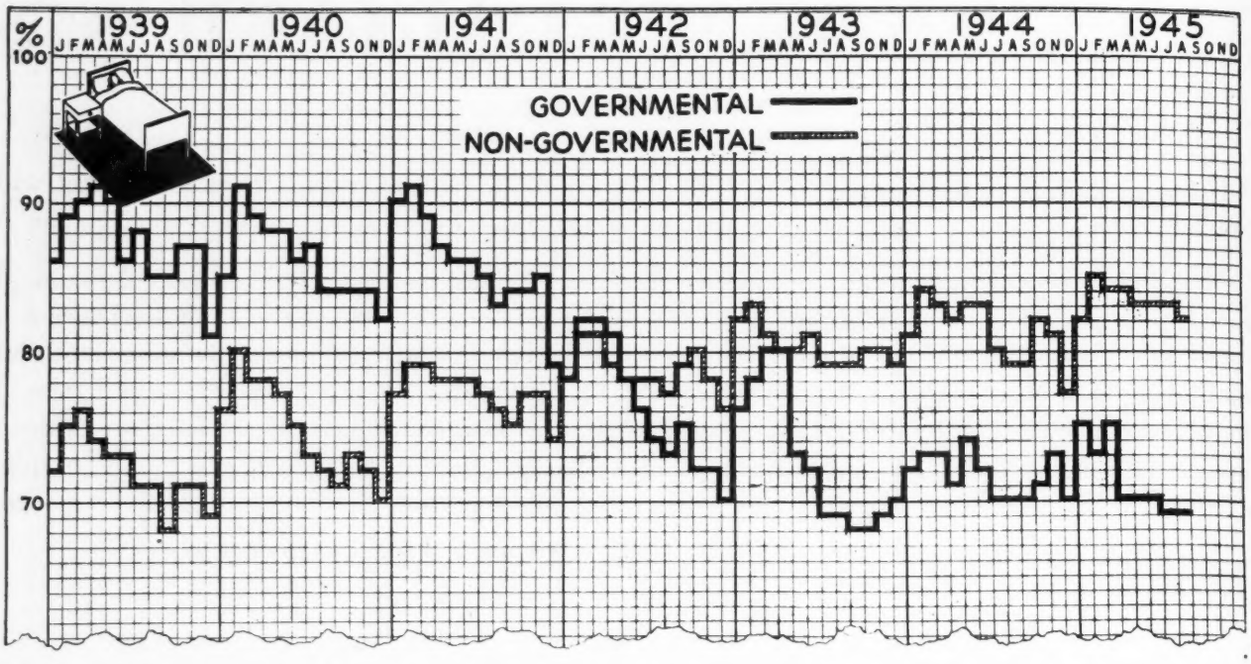
Cooperation of government, voluntary institutions, capital, labor and professional groups in solving the problem of medical care is recommended by Mr. Pink, president of the Associated Hospital Service of New York.

"It is not possible to pull out of a hat any detailed plan that will solve the problem of medical care in the United States," Mr. Pink says. He opposes setting aside all precedents in favor of revolutionary measures.

While the nation is pondering the problem of compulsory health insurance, the author recommends that more stress be placed on preventive medicine, especially public health education, that medical centers be provided in small cities and towns adjacent to those rural areas where there is no adequate medical service, that greater efforts be made in urban areas to bring general practitioners within the influence of existing hospital centers and that adequate hospital facilities be made available by government for tuberculosis and for communicable and mental disease care.

Mr. Pink admits that voluntary medical care insurance is difficult but states that it "may become an important means for bringing adequate medical care to the public."—ALDEN B. MILLS.

Occupancy in Voluntary Hospitals Drops Slightly



Hospital occupancy dropped slightly in the nongovernmental general group and remained the same in the governmental institutions during August, according to preliminary reports. New Orleans, San Francisco and St. Paul reported extremely high occupancies in the voluntary hospital group for the recent month.

A total of $15,000,000 of new construction was reported in the period from August 20 to September 17. There were 40 new projects, of which 38 gave cost figures, and also a large group of late reports.

Thirteen new hospitals will cost $4,000,000; 16 additions will cost $4,300,000; four alterations will cost $500,000 and five nurses' homes will come to $700,000. There were late reports totaling $5,500,000. Total costs since January 1 are $184,800,000.

AFTER HOURS

Life Begins This Month

A PUBLISHER of periodicals may sometimes lament the transient nature of his product, seeing the output of each month pass into obsolescence when the moon changes. This is in the nature of most magazines, but on the credit side of the same account is the dynamic quality of each new issue, bearing as it does an account of the activities of the thirty days just past, revealing the freshest and newest thinking, projecting ideas just as they shed the shell from which they have been hatched.

Our lament is tempered with the recurring realization that our issues do not die, one by one, as the months pass. We receive innumerable requests for issues missing from a set about to be bound. We know of many hospitals which proudly maintain complete files from our first issue in 1913. Just the other day one of our editors mentioned quite casually that we were still receiving requests for reprints of an article published twenty-one months ago. And this was not an isolated case, but a somewhat common occurrence. Mail still comes to our office addressed to the person of a former editor who severed his connection with us more than a decade ago, indicating that his name had been taken from the masthead in an old copy which, by all normal calculation, was quite literally a dead issue.

It is gratifying to look back over the years, across a panorama of monthly issues, each timely and complete within itself, and to note how many ideas that once were timely have since become timeless. Standardization in hospitals, now a fact, was projected in magazine articles long before the program of the American College of Surgeons came into being, in fact, before the college itself was organized.

Advancements in hospital design, recorded long ago as a matter of the moment, have become accepted practice. Hospitals being built today incorporate features and ideas that were set down in magazine articles a decade ago.

When we stop to think about it, we find ourselves perpetually reminded that not only are copies of the magazine saved and referred to for many years, but that ideas originated or fostered by the publishing organization have been a powerful factor in molding the thought and practice of the field.

It is a good thing for a publisher, for an editor, to come face to face with this evidence from time to time. It emphasizes his responsibility for each item that appears in each issue. We suspect that publishers and editors who make very sure that each issue of a periodical really comes to life need never fear for its longevity.

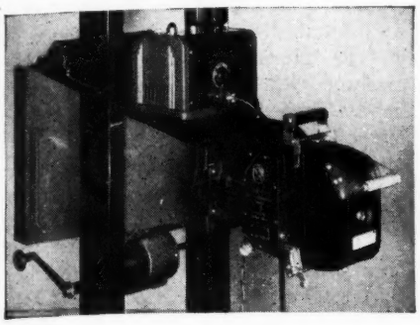
—THE PUBLISHER

What's New for Hospitals

OCTOBER 1945 SUPPLEMENT TO THE MODERN HOSPITAL

Mass Radiography Unit

A new series of photo-roentgen units for mass radiography has been developed



for use with 70 mm. roll film as well as 4 by 5 inch cut film by General Electric X-Ray Corporation. Use of the G-E photo-timer makes it possible to control the x-ray exposure automatically.

The interchangeable use of either the 70 mm. serial camera especially designed for the use of roll film, the 4 by 5 inch single exposure film back or the 4 by 10 inch stereo film back is possible because of the special engineering of the unit. Thus cut film can be used for individual examinations, as of entering hospital patients, new personnel and special cases, and the roll film can be used when the hospital x-ray department does mass chest examinations among out-patients or for special groups.

The special unit for developing the film has a motor-driven mechanism which passes the film through the solution from one spool to another until the process is completed. The developing procedure, exclusive of drying, requires about 45 minutes. **General Electric X-Ray Corp., Dept. MH, 175 W. Jackson Blvd., Chicago 4. (Key No. 2685)**

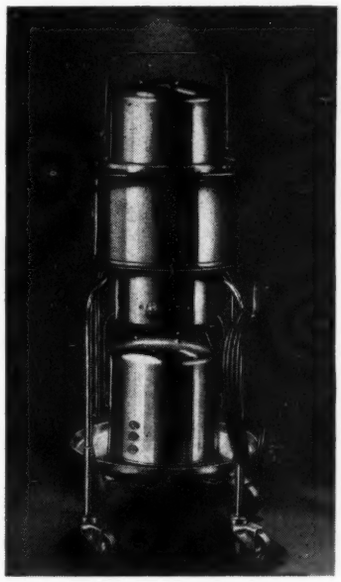
Bed Size Heating Pad

A new type of electrically heated pad known as Thermopad, 30 by 72 inches in size, has been developed which employs the principle applied in heated flying suits. When the pad is placed on the mattress of a hospital bed and the bed is made in the regular way, it can be switched on and the patient kept warm for any required period. It is so designed that neither the patient nor the operator can suffer burns from its use. The heat control device permits of low temperatures for regular use and higher temperatures where fever therapy is indicated.

Constructed of two layers of sterilized goat's hair felt between which is a specially constructed density heating unit, the Thermopad is simply plugged into any light socket, either A.C. or D.C. The heating wires are encased in channels of fiber glass fabric and can expand or contract freely. The end third of the pad has increased heat for the feet and lower part of the legs. The pad can be used on the operating table for prolonged operative cases and is effective for post-operative care. **Therm-Aire Equipment Co., Dept. MH, 2513 Gallatin Rd., Nashville 6, Tenn. (Key No. 2835)**

Polio-Pak Heater

The Vollrath stainless steel Polio-Pak Heater has been designed for preparing



hot packs quickly and in quantity for bedside application in the treatment of poliomyelitis, infections and vascular and muscular congestions. It can also be used for any physical therapy where hot packs, either moist or dry, are needed.

A compact, portable unit, the heater provides a safe, simple, convenient means of preparing hot packs. It can be used wherever an electric outlet is available. Two stainless steel dome shaped "pak-pails" provide continuous treatment, a red signal light indicates when the unit is in operation and there is a thermostatic switch. The unit weighs approximately 50 pounds, is 37 inches high and is equipped with easily rolling rubber tired wheels. **The Vollrath Co., Dept. MH, Sheboygan, Wis. (Key No. 2831)**

Glass and Plastic Fracture Cast

An interesting application of Fiberglas has been made in a new fracture cast. A flexible roll of Fiberglas and plastic known as Aire-Lite Bandage, the product is immersed in a setting solution before applying and hardens into a rigid cast which is light in weight and does not block x-ray penetration.

The new bandage is a soft, flexible, elastic knitted composition of cellulose acetate and Fiberglas. After immersion in the setting liquid and application, the bandage completely immobilizes the injured part so that the patient retains his original freedom of movement. Free circulation of light and air because of the mesh construction makes the cast cool and comfortable and since it does not absorb water, the patient can bathe while wearing it. The component parts are nontoxic and nonirritant and the cast can be used over open wounds. **Tower Co., Inc., Dept. MH, 1008 Western Ave., Seattle, Wash. (Key No. 2836)**

Taylor Poly Phosphate Comparator

Designed to reduce the time factor in determining poly phosphates, the new Taylor Poly Phosphate Comparator requires only 20 minutes for this operation. These analyses are necessary in power plants and hot water systems to prevent feed line deposition and in air conditioning and refrigeration units, laundry machinery, dishwashers and similar equipment to prevent deposition and corrosion.

The outfit consists of a comparison block containing 8 standards, 2 comparison tubes, funnel, filter paper, graduate, flask and reagents. It is contained in a small wooden carrying case for easy

transport to the place of need. **W. A. Taylor & Co., Dept. MH, 7300 York Rd., Baltimore, Md. (Key No. 2689)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 288

"Ducky" Nipple

The new "Ducky" nursing nipple is scientifically designed to make possible the comfortable feeding of infants without the necessity of holding the bottle in an elevated position. Made of rubber latex to fit all standard size nursing bottles, the new nipple has a patented air vent which is designed to eliminate the possibility of nipple collapse during feeding. Research has been conducted with pediatricians and nurses who have approved of the special features of this new nipple and found them satisfactory and effective. **Seamless Rubber Co., Dept. MH, New Haven 3, Conn. (Key No. 2827)**

Exterior Masonry Paint

Mason-Cote is an exterior masonry paint developed especially to provide a simplified and improved method of coating exterior masonry surfaces. Unaffected by temperature extremes, Mason-Cote has exceptional adhesion and can be applied over damp brick, concrete, cement, stucco, cinder block and similar surfaces. It is an oil paint product, resistant to lime, which is easily applied by brush or spray. **Wilbur & Williams Paint Corp., Dept. MH, 33 St. James Ave., Boston 16, Mass. (Key No. 2734)**

Germicidal Lamps

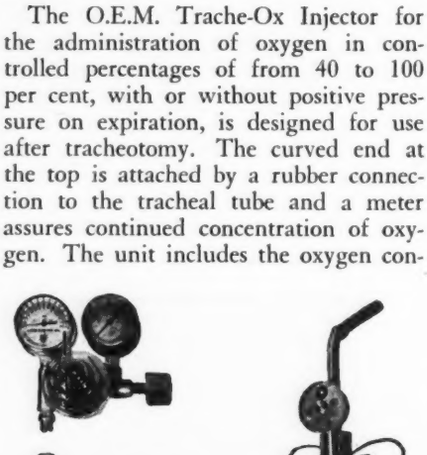
Two new types of germicidal lamps have been developed by Sylvania Electric Products Inc. Type A is designed for general air sterilization such as is effective in preventing cross infection in the hospital and for sterilization of dishes and glassware. Air sterilization for large food storage refrigerators and for air conditioning ducts is handled by the type B lamps. Both types are rated at 2500 hours life and can be operated with the conventional ballasts, sockets and starters used with standard fluorescent lamps. **Sylvania Electric Products Inc., Dept. MH, Salem, Mass. (Key No. 2774)**

Rupel Automatic Bladder Irrigator

A completely automatic apparatus for tidal drainage of the urinary bladder employs simple physical principles for its operation. Controlled frequency of irrigation and controlled volume of fluid per irrigation are provided in this simple device, known as the Rupel Automatic Bladder Irrigator, which requires a minimum of nursing attention during operation. **Clay-Adams Co., Inc., Dept. MH, 44 E. 23rd St., New York 10. (Key No. 2694)**

Oxygen Injector After Tracheotomy

The O.E.M. Trache-Ox Injector for the administration of oxygen in controlled percentages of from 40 to 100 per cent, with or without positive pressure on expiration, is designed for use after tracheotomy. The curved end at the top is attached by a rubber connection to the tracheal tube and a meter assures continued concentration of oxygen. The unit includes the oxygen concentration meter, the positive pressure attachment and the easy operating inspiratory valve with safety valve. The apparatus is light and rests on the patient's chest without discomfort. **Oxygen Equipment Mfg. Co., Dept. MH, 405 E. 62nd St., New York 21. (Key No. 2744)**



Bedside Floor Lamp

An improved bedside floor lamp made of machined steel and brass with spray bronze finish, available with or without a night light below mattress level, has been announced by the Clark Linen and Equipment Company. The 9 inch swivel shade is adjustable for use in examinations and can be set at any angle in a 360 degree arc. An outlet plug for electrical devices is conveniently located and contains its own switch independent of the light itself. A 9 foot rubber covered cord and unbreakable plug are attached. **Clark Linen & Equipment Co., Dept. MH, 303 W. Monroe St., Chicago 6. (Key No. 2798)**

Rechargeable Flashlight Battery

An improved model rechargeable flashlight battery which is designed to give 40 per cent greater capacity and higher sustained bright light has recently been developed. **Ideal Commutator Dresser Co., Dept. MH, Sycamore, Ill. (Key No. 2696)**

Tablet Machine

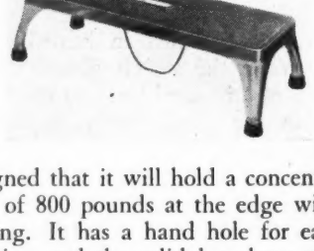
Hospital pharmacies and laboratories will be interested in the Eureka tablet machine which has been improved to increase its value in laboratory work and in the manufacture of tablets where only small or moderate quantities are required. The frame of the machine has been strengthened and the feeding device, ejection cam and plunger have been improved for greater efficiency. **F. J. Stokes Machine Co., Dept. MH, 5830 E. Tabor Rd., Philadelphia 30, Pa. (Key No. 2746)**

Food Storage Refrigerators

Two new heavy duty refrigerators designed to hold 1000 and 1600 pounds of frosted foods respectively have recently been developed by Jewett Refrigerator Company. The heavy duty construction and insulation reduce operating costs and quick access to the interior is provided by the counter-balanced top covers which can be locked if desired. The self-contained condensing unit maintains five degrees below zero F. in the storage compartment and can be adjusted to 20 degrees below zero. The units are constructed in 25 cubic feet and 40 cubic feet capacity. **Jewett Refrigerator Co., Dept. MH, 2 Letchworth St., Buffalo 13, N. Y. (Key No. 2780)**

Foot Stool

An operator's foot stool cast from solid aluminum to provide lightweight sturdiness has been developed by Aircraft Specialties Company. The stool is so designed that it will hold a concentrated load of 800 pounds at the edge without tipping. It has a hand hole for ease in carrying and the solid legs have rubber tips. **ASCO Manufacturing Co., Dept. MH, 601 S. Anderson, Los Angeles 23, Calif. (Key No. 2738)**



Address manufacturers for further information and prices—or use Readers' Service blank on page 288

PHARMACEUTICALS

Liquid Vitamin B Complex

Infa-Concemin is a new liquid vitamin B complex and iron product for infants and children. The product has the complete vitamin B complex contained in a special base of liver and rice bran with ferrous sulfate. It is pleasant tasting and can be administered in milk or fruit juice or given undiluted with a dropper or spoon. Each 30 cc. package contains a dropper for convenience in measuring. **Wm. S. Merrell Co., Dept. MH, Cincinnati 15, Ohio. (Key No. 2705)**

Alcohol-Dextrose Solution

Alcohol, 5 per cent v/v in Beclysyl is an intravenous bulk solution for the control of postoperative pain and restlessness which also provides nourishment in the form of 5 per cent dextrose-saline plus thiamine, riboflavin and nicotinamide. It is designed to prevent deficiencies in the vitamin B complex while producing a sedative effect. It is supplied in 1000 cc. bottles in cases of 6. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 2707)**

Promin Jelly

Developed for topical application in treatment of accessible nonpulmonary tuberculous lesions. Promin Jelly contains 5 per cent Promin in a water soluble jelly base. It is indicated in treatment of such tuberculous lesions as isolated abscesses, soft tissue lesions and abscesses associated with tuberculosis of the glands or bone.

Sufficiently fluid to permit ready application, the product is of such consistency that diffusion is limited. It may be applied directly from the tube or drawn into a syringe for treatment of deep abscesses or sinuses. The product is supplied in 1¾ ounce collapsible tubes. **Parke, Davis & Co., Dept. MH, Detroit, 32, Mich. (Key No. 2709)**

Pyrithiad

Designed for the treatment of nausea and vomiting of pregnancy, adolescent acne, radiation sickness and certain other conditions, Pyrithiad is a combination of pyridoxine hydrochloride and thiamine hydrochloride. It is available in tablet form for oral administration, each tablet containing 20 mg. pyridoxine hydrochloride and 2 mg. thiamine hydrochloride, and in solution for parenteral administration. **Lakeside Laboratories, Dept. MH, 1707 E. North Ave., Milwaukee 1, Wis. (Key No. 2656)**

Penicillin Products

Two new developments in penicillin therapy have been announced by Cutter Laboratories. The first, Pen-Troches, has been developed for treatment of Vincent's Angina and other infections of the oral cavity caused by penicillin sensitive organisms. The troches are supplied in vials of 20, each troche containing 500 units of calcium penicillin.

Calcium Penicillin in sesame oil and beeswax has been developed to slow up absorption of penicillin and reduce the number of injections required in parenteral therapy. This product has been found to remain stable for nine months under proper refrigeration and is indicated in all infections where parenteral use of penicillin has proved effective. Penicillin in Oil and Wax-Cutter is supplied in two concentrations, 100,000 units per cc. and 200,000 units per cc., each in a 5 cc. vial. **Cutter Laboratories, Dept. MH, Berkeley 1, Calif. (Key No. 2842)**

Digitaline Nativelle

A potent, uniform product for oral digitalization which is completely absorbed from the gastrointestinal tract is offered in Digitaline Nativelle. Complete digitalization is possible in a short time without local irritant action and dosage is governed by weight, in precise amounts. The product is available in tablets and also in ampules for intravenous administration. **Varick Pharmacal Co., Dept. MH, 75 Varick St., New York 13, N. Y. (Key No. 2704)**

Oral Penicillin

Orally active preparations of penicillin have been developed to replace or supplement intramuscular injection. Two forms are offered by Wyeth, one, Penoral, using sodium citrate as the buffer to prevent destruction of the penicillin through attack by gastric acidity or alkalinity, and the other, Amphocillin, to be combined with Amphojel.

Three or four times the established parenteral dose of penicillin is necessary with oral administration. The product can be used to supplement parenteral therapy, as a follow up treatment in acute conditions or for the complete treatment. **Wyeth, Inc., Dept. MH, 1600 Arch St., Philadelphia 3, Pa. (Key No. 2838)**

Becomco

Complete B complex therapy is provided in Becomco, a palatable, cocoa flavored syrup. It is supplied in 3 ounce and pint bottles. **George A. Breon & Co., Dept. MH, 2000 Baltimore Ave., Kansas City 10, Mo. (Key No. 2803)**

RECENT CATALOGS AND BOOKLETS

• A folder from Eli Lilly and Company, Indianapolis 6, Ind., announces the addition of **Diphtheria Toxoid-Tetanus Toxoid Combined with Pertussis Vaccine, Fluid and Diphtheria Toxoid-Tetanus Toxoid Combined with Pertussis, Alum Precipitated,** to its list of immunizing biologicals. **(Key No. 2849)**

• The maintenance department of the hospital will be interested in a booklet recently issued by the B. F. Goodrich Co., Akron, Ohio, on **"Natural and Synthetic Rubber Adhesives."** Directions for the use of rubber cements, how to choose the right type for various uses and the difference between the vulcanizing and non-vulcanizing types of rubber cement are included. **(Key No. 2725)**

• Information on the effective use of motion picture equipment is presented in a series of bulletins prepared by Bell & Howell, 7100 McCormick Rd., Chicago 45. The most recent is entitled **"Architects' Visual Equipment Handbook." (Key No. 2722)**

• The prefabricated room-unit developed by Hospital Cabinets and Equipment, Inc., 1700 Walnut St., Philadelphia 3, Pa., is illustrated and described in an attractive booklet entitled **"Tomorrow's Hospital Today!"** Several pages of room layout drawings are included with details of equipment in each. **(Key No. 2730)**

• **"Cemcoat Filler and Dustproofer"** is the title of a brochure designed to assist maintenance men in the protection of cement floors and in producing a more attractive appearance. Suggestions for protecting worn painted areas of cement floors and building up high and low spots are offered. The booklet has been prepared by the Building Products Division of L. Sonneborn Sons., Inc., 88 Lexington Ave., New York 16. **(Key No. 2759)**

• Newcomb sound systems are fully described and illustrated in a leaflet, **"Newcomb, the Sound of Quality,"** prepared by Newcomb Audio Products Co., 2815 S. Hill St., Los Angeles 7, Calif. Included are data on amplification systems with individual control boxes for installation in hospitals which permit each patient to have his own listening device. **(Key No. 2713)**

• **"A New Approach to Therapy in Dysmenorrhea"** is the title of a booklet containing anatomical plates in full color prepared by G. D. Searle & Co., Box 5110, Chicago. A bibliography on this subject is included. **(Key No. 2732)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 288

• The special services rendered by sound systems and the arrangement of controls, loudspeakers and microphones in various types of institutions including hospitals, are detailed in a brochure on **"RCA Sound Systems"** issued by the RCA Victor Division of the Radio Corporation of America, Camden, N. J. **(Key No. 2820)**

• The use of **Mertricone (Conant's Solution)** for improved chemical sterilization is discussed in a pamphlet published by William H. Rorer, Inc., Philadelphia 6, Pa. **(Key No. 2763)**

• The various electrical devices needed in the practice of **"Physical Medicine"** are illustrated and described in a booklet of that name issued by the Burdick Corp., Milton, Wis. **(Key No. 2760)**

• **"The Nutritive Value of Vegetables"** is the title of a booklet containing a series of articles by the same name from The Nutritional Observatory. The booklet has been edited and published by the staff of the Heinz Nutritional Research Division in Mellon Institute and is distributed by H. J. Heinz Co., Pittsburgh, Pa. **(Key No. 2845)**

• **"Bailey Thermo-Hydraulic Feed Water Regulators"** is the title of a bulletin describing and illustrating improved designs of thermo-hydraulic generators and bellows-operated feed water regulator valves suitable for feed lines ranging in size from ¾ to 6 inches inclusive. A colored schematic illustration demonstrating the thermo-hydraulic principle is included in this Bulletin No. 83-C issued by Bailey Meter Co., Cleveland 10, Ohio. **(Key No. 2808)**

• **Tufcrete Resurfacer,** a scientifically developed product for use indoors or out on worn floors of wood, concrete, brick, asphalt, stone or other composition, as well as on sidewalks, steps, tennis courts and other surfaces, is described in detail in a leaflet recently released by the Tufcrete Co., 625 S. W. Ninth St., Des Moines 9, Iowa. **(Key No. 2811)**

• The use of concrete masonry in construction is covered in a kit prepared by the Besser Mfg. Co., Alpena, Mich., entitled **"Your file of information on Modern Building Material."** Complete information is included which should be of interest to hospital administrators and architects interested in construction problems. **(Key No. 2721)**

• Answers to questions on the subject of air disinfection by lighting are given in a four page folder prepared by Edwin F. Guth Co., 2615 Washington Ave., St. Louis 3, Mo., and entitled **"Germ-Killing Lights for Personal Protection."** **(Key No. 2728)**

• Helpful hints on floor maintenance problems, effective use and care of Holt floor sanding and maintenance machines, a Stain Removal Chart and descriptive and illustrative information on all types of Holt machines as well as accessories are some of the items covered in a new loose-leaf catalog recently issued by Holt Mfg. Co., 651 Twentieth St., Oakland 12, Calif. **(Key No. 2806)**

Manufacturers' Plant News

The General Electric X-Ray Corporation announces the removal of its main office from the plant at 2012 Jackson Boulevard to 175 West Jackson Boulevard, Chicago. Moving the offices to the new location in the Insurance Exchange Building released an additional five story building for manufacturing purposes. **(Key No. 2862)**

Announcement has been received of the change of name of **Cheplin Laboratories, Inc.,** Syracuse, N. Y., to **Bristol Laboratories, Inc.** This company, recently purchased by Bristol-Myers Company, produces penicillin in addition to a comprehensive line of parenterals and specialty products. **(Key No. 2863)**

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Bessie Covert,
Editor, "What's New for Hospitals"

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- ☐ 2763 Mertricone
- ☐ 2774 Germicidal Lamps
- ☐ 2780 Food Storage Refrigerators
- ☐ 2798 Bedside Floor Lamp
- ☐ 2803 Becomco
- ☐ 2806 Catalog
- ☐ 2808 "Bailey Thermo-Hydraulic Feed Water Regulators"
- ☐ 2811 Tufcrete Resurfacer
- ☐ 2820 "RCA Sound Systems"
- ☐ 2827 "Ducky" Nipple
- ☐ 2831 Polio-Pak Heater
- ☐ 2835 Bed Size Heating Pad
- ☐ 2836 Glass and Plastic Fracture Cast
- ☐ 2838 Oral Penicillin
- ☐ 2842 Penicillin Products
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